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The Development of Psychogeriatric Services in England from circa 1940 until 1989

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The Development of Psychogeriatric Services in
England
from *circa* 1940 until 1989

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Submitted for the degree of PhD

King's College, London

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Abstract

The clinical specialty of psychogeriatrics developed to provide dedicated mental health services for people over age 65, often treating people with complex combinations of mental, physical and social difficulties.

Clinical reports in 1943/4 showed that physically and mentally unwell older people could benefit from active treatment, but the old age health specialties – geriatrics and psychogeriatrics – followed different paths of development. By 1970 there were about 200 consultants in geriatrics, but merely a handful of psychogeriatricians. Psychogeriatric services did not fit conveniently into policies and plans categorised as either psychiatric or geriatric, and suffered from lack of defined responsibility at all levels of health service management.

Political, economic, demographic, legal, social, epidemiological, clinical and scientific factors influenced service development. Negative attitudes towards older people and unwillingness of society, including the medical profession, to provide actively for them were repeated obstacles. Tensions existed between doctors advocating better mental health services for older people and various influential committees nationally and locally. Debates over responsibilities and allocation of resources, and professionals' attitudes towards the new psychogeriatricians and their specialty, contributed to its tortuous development.

Leaders in the specialty showed determination, dedication, clinical acumen, organisational and research skills, and the ability to motivate and inspire others. In 1989, the Department of Health recognised psychogeriatrics as a medical specialty. By that time, specialist psychogeriatric services had increased substantially and were available to over 70% of the UK population. Until recognition, there were obstacles to providing appropriate specialist training for psychiatrists and the government did not collect relevant and specific data to assist with developing and monitoring services. Lack of data was associated with difficulty obtaining an equitable allocation of resources, despite clinical and epidemiological research indicating that dedicated, specialist-led services were needed and effective.

Dedicated to

Tom Arie

and

David Jolley

for their teaching and friendship

and with gratitude to all the pioneers of psychogeriatrics

Acknowledgements

In the course of this project, it has been a privilege to meet many of the founders of psychogeriatrics, and to have heard about their lives and their work. Some participated in a witness seminar. Some were interviewed individually, answered e-mails and letters and gave me access to their personal archives. They are acknowledged in the footnotes and bibliography.

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List of abbreviations

AEGIS	Aid for the Elderly in Government Institutions
<i>Age Ageing</i>	<i>Age and Ageing</i>
APSW	Association of Psychiatric Social Workers
BASW	British Association of Social Workers
BBC	British Broadcasting Corporation
BGS(A)	British Geriatrics Society (Archives)
<i>BJGP</i>	<i>British Journal of General Practice</i>
<i>BJPSM</i>	<i>British Journal of Preventive and Social Medicine</i>
<i>BJPsych</i>	<i>British Journal of Psychiatry</i>
<i>BJSW</i>	<i>British Journal of Social Work</i>
BLSA	British Library Sound Archives
BMA(A)	British Medical Association (Archives)
BMHA	Bethlem-Maudsley Hospital Archives
<i>BM(H)G</i>	<i>Bethlem Maudsley (Hospital) Gazette</i>
<i>BMJ</i>	<i>British Medical Journal</i>
<i>c.</i>	<i>circa</i>
CHE	Centre for Health Economics, York
Cmd., Cmnd.	Command Paper presented to Parliament
CMO	Chief Medical Officer
CPA	Centre for Policy on Ageing (previously NCCOP)
CUP	Cambridge University Press
DGH	District general hospital
DHSS	Department of Health and Social Security
DoH	Department of Health
DV	Domiciliary visit
ECT	Electro-convulsive therapy
ed.	Edited by
EFCC	Executive and Finance Committee of Council, RCPsych
EMS	Emergency Medical Service
E(S)MI	Elderly (Severely) Mentally Ill/Infirm
FP	Felix Post, archives

FoI	Freedom of Information
GDP	Gross Domestic Product
GMC	General Medical Council
GP(s)	General practitioner(s)
GPOA	Group for the Psychiatry of Old Age
HAS	Hospital (later, Health) Advisory Service
HC	House of Commons
HMSO	His / Her Majesty's Stationery Office
<i>HoP</i>	<i>History of Psychiatry</i>
IAG	International Association of Gerontology
<i>Ibid.</i>	<i>Ibidem</i> (Latin, 'in the same place')
ICD	International Classification of Diseases
<i>IJGP</i>	<i>International Journal of Geriatric Psychiatry</i>
<i>JCGP</i>	<i>Journal of the College of General Practitioners</i>
JCHPT	Joint Committee on Higher Psychiatric Training, RCPsych
<i>JMS</i>	<i>Journal of Mental Science</i>
<i>JRCGP</i>	<i>Journal of the Royal College of General Practitioners</i>
<i>JRSM</i>	<i>Journal of the Royal Society of Medicine</i>
KFL	King's Fund Library, London
LMC	Local Medical Committee
MHA	Mental Health Act 1959
MH-SAC	Mental Health Standing Advisory Committee
MoH	Ministry of Health
MP	Member of Parliament
MSCE	Medical Society for the Care of the Elderly (subsequently BGS)
MTA	Mental Treatment Act 1930
NAMH	National Association for Mental Health (later MIND)
NCCOP	National Corporation for the Care of Old People (later CPA)
NHS	National Health Service
NHS Act	National Health Service Act 1946
<i>NN</i>	<i>News and Notes of the BJPsych</i> (1972-1977)
NOPWC	National Old Peoples' Welfare Committee

NPHT	Nuffield Provincial Hospitals Trust
OAP	<i>Old Age Psychiatrist</i> , Old Age Faculty Newsletter, RCPsych
ODNB	<i>Oxford Dictionary of National Biography</i>
OECD	Organisation for Economic Co-operation and Development
OGL	Open Government Licence
OHE	Office of Health Economics
ONS	Office for National Statistics
OP	Occasional paper
OUP	Oxford University Press
PEP	Political and Economic Planning
PJ	Peter Jefferys, archives
PMO	Principal Medical Officer
PRSM	<i>Proceedings of the Royal Society of Medicine</i>
PSIGE	Psychology Special Interest Group in the Elderly
PSSRU	Personal Social Services Research Unit
PSW	Psychiatric Social Worker
q.	qualified
QALY	Quality adjusted life year
RAWP	Resource Allocation Working Party
RCGP	Royal College of General Practitioners
RCN(A)	Royal College of Nursing (Archives)
RCP(A)	Royal College of Physicians of London (Archives)
RCPsych(A)	Royal College of Psychiatrists (Archives)
RHA	Regional Hospital Authority
RHB	Regional Hospital Board
RMPA	Royal Medico-Psychological Association
SAC	Standing Advisory Committee
SHHD	Scottish Home and Health Department
SHM	<i>Social History of Medicine</i>
SPOA	Section for the Psychiatry of Old Age
SR	Senior Registrar: training grade before consultant
STD	Sexually transmitted disease
SWT	<i>Social Work Today</i>

TA	Tom Arie, archives
TNA	The National Archives
tr.	Translated by
TSO	The Stationery Office
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation
‘Witness’	Witness seminar, <i>Development of Old Age Psychiatry</i>
WL	Wellcome Library, London
WPA	World Psychiatric Association

Introduction

I started as a lone doctor, bewildered and frightened by the multitude of apparently hopelessly ill and deteriorating patients. I end as a member of a professional team and with the certainty of being able to help to an important extent almost all my patients.

Dr. Felix Post, reflecting on his career in psychiatry, 1941 to 1978¹

In 1989 I was a trainee psychiatrist at Withington Hospital, Manchester. One morning, the senior consultant psychogeriatrician, Dr David Jolley, came bounding up the back-stairs to the offices on the top floor of the Victorian workhouse block which housed the ‘psychogeriatric’ wards. He announced exuberantly: ‘We are a specialty! We are a specialty!’ He was rejoicing because the Department of Health had officially recognised psychogeriatrics as a specialty.

At the time I wondered what he meant: we were doing the work, weren’t we? I was too embarrassed to ask, but it whetted my appetite to find out. This thesis is the outcome. The central question it seeks to explore is: how did psychogeriatrics develop and achieve recognition as a specialty?

Until the mid-1950s, psychiatric symptoms in older people were usually diagnosed as untreatable ‘senile dementia’ and managed in a uniform way. It was then shown that older people could suffer from a variety of psychiatric disorders.² Some of these disorders could be treated as effectively as in younger people³ and symptoms occurring in other, incurable conditions could be ameliorated. Consequently, psychiatrists interested in working with older people aimed to offer diagnosis and treatment for all categories of psychiatric disorder. This was compatible with the scope of psychogeriatrics proposed by the World Health Organisation (WHO) in 1972: ‘the various forms of mental

¹ Felix Post, ‘Then and now’ *British Journal of Psychiatry (BJPsych)* (1978) 133: 83-86 85

² Martin Roth, ‘The natural history of mental disorders in old age’ *Journal of Mental Science (JMS)* (1955) 101: 281-301

³ Felix Post, *The Significance of Affective Symptoms in Old Age: a follow up study of 100 patients* (London: OUP, 1962); Felix Post, *Persistent Persecutory States of the Elderly* (Oxford: Pergamon Press, 1966)

disorders of old age, their epidemiology, origin, prevention, development, and treatment'.⁴

Despite evidence of benefit, services only developed slowly. Society did not demand them, hence there was limited political motivation and initiative to develop and resource them. Nevertheless, there was a huge expansion of dedicated hospital and community psychiatric services for older people, mainly over 65 years, from none in the early 1940s to over 70% of the population having access to them by the late 1980s. Leadership and inspiration for this expansion came mainly from the medical profession, especially a small number of psychiatrists.

There is a dearth of historical studies of the development of psychogeriatric services leaving a gap in knowledge which warrants investigation. This thesis analyses the formation of those services, from the beginning *circa* 1940 until official recognition in 1989.

The research questions

The following questions have guided this study:

1. The services

Why were psychogeriatric services needed? How did they develop between c.1940 and 1989? How did specialty recognition come about? What was achieved by 1989?

2. The players

Which individuals, professions and institutions led the developments? What or who helped or hindered them?

3. External influences

What were the chief influences, from government and wider society, on developing services and gaining recognition as a specialty?

⁴ World Health Organisation (WHO), *Psychogeriatrics* (Geneva: WHO, 1972) 11

Defining old age and the needs of older people

Some medical practitioners in the nineteenth century acknowledged that older people had medical needs for which their doctors required specific knowledge and skills.⁵ Concerns about illness in old age paralleled those about illness in childhood.⁶ It was recognized that children and older people were physiologically different from young and middle-aged adults, with distinct illness presentations and treatment requirements. The term 'paediatrics', for children's health services, dates from the mid-nineteenth century.⁷ 'Geriatrics' was coined by Ignatz Nascher in 1909 (*geras*, old age; *iatrikos*, relating to the physician).⁸

Life expectancy at birth increased steadily from the early twentieth century, mainly because more people survived childhood and adolescence.⁹ Living to an advanced age, contributing to society and requiring care from it were not new.¹⁰ The difference in the twentieth century was that more people achieved it (Fig 1). A long, healthy and active retirement for many people with a relatively short decline in very late life¹¹ became a normal expectation by the later decades of the twentieth century.

⁵ George Day, *A Practical Treatise on the Domestic Management and Most Important Diseases of Advanced Life* (London: T and W Boone, 1849); Francis Anstie, 'On certain nervous affections of old persons' *JMS* (1870) 16: 31-41

⁶ Malford Thewlis, *Geriatrics: a treatise on senile conditions, diseases of advanced life, and care of the aged* (St Louis: CV Mosby, 1919) 7

⁷ 'paediatric', *Oxford English Dictionary Online*. OUP, Sept. 2012.
<http://www.oed.com/view/Entry/135954?redirectedFrom=paediatric> accessed 30.11.2012

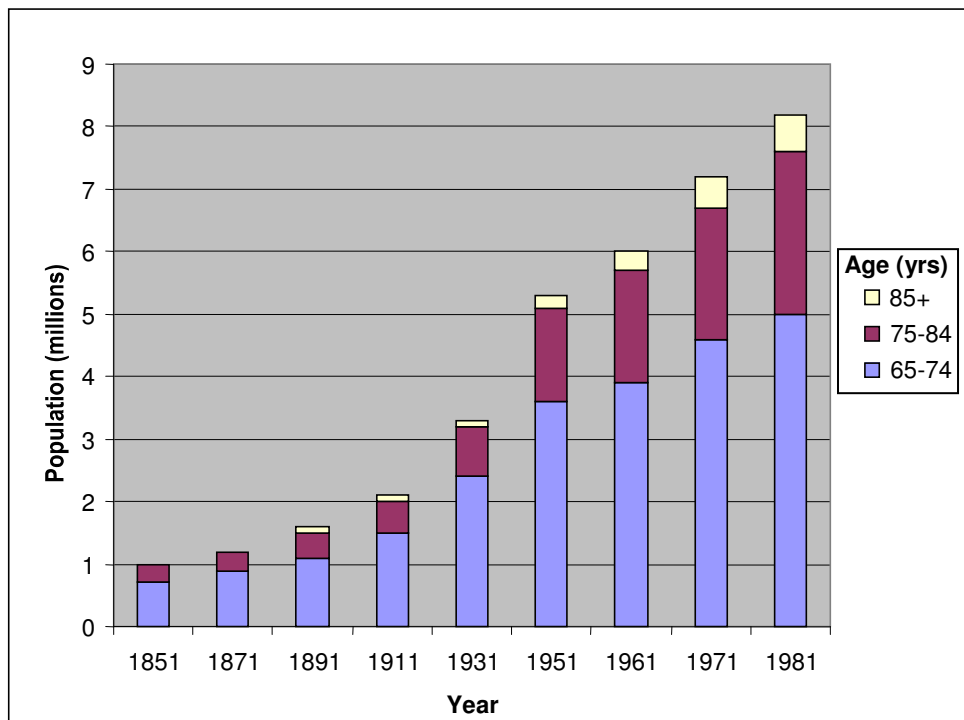
⁸ Ignatz Nascher, 'Geriatrics' *New York Medical Journal* (1909) 90: 358-359

⁹ Office for National Statistics (ONS), 'Decennial Life Tables, No.16 (2000-2002)' *Population Trends* (2009) 136: 3

¹⁰ Pat Thane, 'Geriatrics' 1092-1115. In: *Companion Encyclopedia of the History of Medicine* ed. William Bynum, Roy Porter (London: Routledge, 1993)

¹¹ Raymond Tallis, *Hippocratic Oaths* (London: Atlantic Book, 2004) 271-273

Fig 1. Population over 65 years, Great Britain, 1851-1981



Source: Office of Population Census and Surveys, *Census Guide 1: Britain's elderly population. 1981 Census* (London: HMSO, 1984) 2. Graph produced by Jacob Hilton

Scholars do not agree on a single definition of old age for use in historical research, but both 'chronological' and 'cultural' age are relevant categories for this study.

'Chronological age' is important for the formulation of laws and policies and to enable population needs to be estimated and plans developed and implemented accordingly. During the period with which most of this study is concerned, age 65 was used to define and establish services for older people. This age definition was socially acceptable at the beginning of the period, corresponding with the age at which many people found it difficult to be fully active and self-supporting. It was widely used for men's retirement age, for men's state pension provision (although from 1940 women qualified for state pension at 60)¹² and for collection of some data by authorities such as the Board of

¹² Pat Thane, *Old Age in English History: past experiences, present issues* (Oxford; OUP, 2000) 390-396

Control, the mental hospitals' regulatory authority.¹³ Chronological age boundaries could, for example, guide general practitioners to refer patients to the appropriate psychiatric department, while psychiatrists knew the limits of their responsibilities. However, rigid chronological age cut-offs were a bureaucratic convenience which had disadvantages as well as advantages. They might exclude some people from treatment which could benefit them: illness and chronological age do not have a linear relationship. For clinical decisions and providing services, age cut-offs are particularly problematic for older people, if society, including the medical profession, holds excessively negative expectations about their health. This links to the concept of 'cultural age' which combines chronological age with aspects of function ('functional age'), degree of independence and capacity for self-care, together with the understanding of old age within a community's value system.¹⁴ As well as relating to expectations of outcome of treatment, cultural age relates to society's priorities about providing various services for older people.

The fluid nature of the term 'old age', which means different things to different people at different times, poses difficulties for interpreting medical sources. 'Older', 'later life', or 'senile' were often used vaguely in medical texts; sometimes 'middle age' would have been more accurate even by contemporary standards. For example, in 1936, Edward Anderson's study of depression in 'later life', included patients age 41 years upwards.¹⁵ In the 1940s, doctors in England concerned with providing treatment for older people chose 60 as the age boundary defining old age, while recognising that many above that age remained healthy and independent.¹⁶ For this dissertation, data are only deemed to relate to older people when age, usually over 60 or 65 years, is stated in source material. 'Younger' is used to refer to anyone below that age.

¹³ Leslie Cook, Eric Cunningham Dax, Walter Maclay, 'The geriatric problem in mental hospitals' *Lancet* (1952) i: 377-382 380

¹⁴ Lynn Botelho, Pat Thane, 'Introduction' 1-12. In: *Women and Ageing in British Society since 1500* ed. Lynn Botelho, Pat Thane (Harlow: Longman, 2001) 4

¹⁵ Edward Anderson, 'Prognosis of the depressions of later life' *JMS* (1936) 82: 559-588 559

¹⁶ British Medical Association (BMA), *The Care and Treatment of the Elderly and Infirm* (London: BMA, 1947) 6-7

People age at different rates, but after about 65, various parameters begin to change more noticeably. Physiological changes such as impaired balance and loss of muscle mass might affect wellbeing and make recovery from physical illness more difficult. Psychological adaptation to retirement or ageing¹⁷ might be problematic for some people. Social difficulties more common in old age, such as bereavement or the poor health of spouse or carers, might complicate clinical management, requiring treatment to be tailored to socio-cultural circumstances. Although the occurrence of many chronic and degenerative disorders, such as dementia, rise in old age and multiple co-morbidities become more common, these conditions are not directly caused by ageing. Age related parameters may all interact and require specific services using a distinct body of clinical knowledge and skills to enable optimum treatment to be provided. Placing disturbed older and younger people together in mixed age wards could be harmful:¹⁸ physical frailty might put older people at risk and different presentations of the same illnesses, different sensitivities to medication, slower rehabilitation and negative staff expectations of recovery could undermine treatment.

Ageism

The term 'ageism', meaning age discrimination, was coined in 1969 in the United States of America (USA).¹⁹ It implies that older people are 'other', are discriminated against and do not have the same rights as the rest of society. Ageism is unlike many other sorts of discrimination, for example, concerning gender, sexual orientation, race and religion, since it relates to our own lives in the future, treating ourselves as 'other'. It appears to be self-perpetuating. Ageing stereotypes are internalised in childhood. Reinforced for decades, and internalized across the life span, often unconsciously, when someone becomes old they may adopt the stereotypes themselves.²⁰ Stereotypically ageist issues

¹⁷ Erik Erikson, *Identity and the Life Cycle* (New York: International Universities Press, 1959)

¹⁸ Peter Connelly, '21 years of old age psychiatry; then, now and the future' *Old Age Psychiatrist (OAP)* (2011) 53: 16-17 16

¹⁹ Robert Butler, 'Age-Is: another form of bigotry' *Gerontologist* (1969) 9: 243-246

²⁰ Becca Levy, 'Stereotype embodiment: a psychosocial approach to aging' *Current Directions in Psychological Science* (2009) 18: 332-336 333

in health care, such as prejudice of the medical profession against older people and the conventional alignment of old age with inevitable deterioration, irreversible decline²¹ and chronic sickness rather than recovery, were noted by Moira Martin in her study of geriatric medicine in the 1950s.²² Death is inevitable, but relentless decline into dependency is not. Ageism, culturally embedded in society, could potentially undermine health care provision for older people and influence analyses by historians.

Creating new medical specialties

The task of providing new services, the main concern of this thesis, overlaps with the complex process of developing new medical specialties. Awareness of this process may help towards understanding the challenges faced by the pioneers of psychogeriatric and geriatric services.²³

Various factors other than changes in clinical knowledge are recognised to drive the creation of new specialties. These include social prestige, public concern, new technology and opportunities for private practice. New specialties also need to relate to the existing organisation of the medical profession and uphold standards of training and accreditation regulated by law. Historian George Rosen recognised a reluctance to develop medical specialties for stigmatised conditions.²⁴ Where they developed, for example for sexually transmitted diseases (STDs) in the early twentieth century, central government required health authorities to establish clinics.²⁵

²¹ Melanie Henwood, 'No sense of urgency: age discrimination in health care' 43-57. In: *Age: the unrecognised discrimination: views to provoke debate* ed. Evelyn McEwen (London: Age Concern England, 1990) 43-44

²² Moira Martin, 'Medical knowledge and medical practice: geriatric medicine in the 1950s' *Social History of Medicine (SHM)* (1995) 7: 443-461 450

²³ George Rosen, *The Specialisation of Medicine with Particular Reference to Ophthalmology*. (New York: Froben Press, 1944) 69, 72; Lindsay Granshaw, *St Marks Hospital London: a social history of a specialist hospital*. (London: King Edward's Hospital Fund for London, 1985)

²⁴ Rosen, *Specialisation*, 4-5, 31, 66, 72

²⁵ George Weisz, *Divide and Conquer: a comparative history of medical specialization* (New York: OUP, 2006) 216-217; R Willcox, 'Fifty years since the conception of an organised venereal diseases service in the United Kingdom' *British Journal of Venereal Diseases* (1967) 43: 1-9 9

Doctors took the lead in developing medical specialties for several reasons. In particular, medical specialties, by definition, include the diagnosis and treatment of illnesses, the essence of medical practice. In addition, doctors had management roles with responsibility for organising clinical services, and many were trained in research methodology. Observing the outcomes of their clinical work could directly affect how they delivered their services.

Post Second World War medical priorities emphasised high-tech interventions, treatment and cure of acute illnesses rather than working with older people often with chronic disorders. Kathleen Jones, professor of social policy, commented that technological advances in health care were not ‘matched by comparable development in social insight’,²⁶ such as towards chronic disorders in old age. Charles Webster, historian of the National Health Service (NHS), commented that, alongside ‘the mentally handicapped’, older people were regarded as part of the dependent ‘growing tide of the unfit’ as more survived to later ages.²⁷ For creating specialist services for older people, negative attitudes and stigma were potentially problematic. The evolution of new specialties for older people would be neither inevitable nor straightforward.

Historiography

According to Andrew Scull, there are two main genres of research in the history of medicine: analyses by professional historians and analyses by ‘a peculiar group of amateurs’,²⁸ often clinicians reviewing their own specialty largely to inform colleagues. Their studies have tended to be written not as a critique, but to document achievements, such as *Madness to Mental Illness*, a history of the Royal College of Psychiatrists (RCPsych).²⁹ Concerning psychogeriatrics in the NHS, most historical studies have been written by

²⁶ Kathleen Jones, *The Making of Social Policy in Britain 1830-1990* (London: Athlone Press, 1991) 209

²⁷ Charles Webster, ‘The elderly and the early National Health Service’ 165-193. In: *Life and Death and the Elderly* ed. Margaret Pelling, Richard Smith (London: Routledge, 1991) 166

²⁸ Andrew Scull, ‘Psychiatry and its historians’ *History of Psychiatry (HoP)* (1991) 2: 239-250 239

²⁹ e.g. Thomas Bewley, *Madness to Mental Illness: a history of the Royal College of Psychiatrists* (London: Royal College of Psychiatrists (RCPsych), 2008)

clinicians in this mode.³⁰ Psychogeriatric services developed patchily in Britain, with a common philosophy and goals but with diverse approaches, so a historical perspective on their development was thought helpful to inspire and guide innovation.³¹ Personal bias, emphasising enthusiasm and achievement, was perhaps inevitable, minimising the wider context and the struggles. This contrasted with the approach of professional historians such as Roy Porter who could be criticised at times for emphasising problems and neglecting achievements.³² Clinicians' studies have been described pejoratively as whiggish, or severely criticized, as by Scull, who argues that 'the resulting distortions have seriously compromised the scholarly usefulness of the accounts offered'.³³

However, clinicians are capable of high quality historical research. German Berrios, emeritus professor of psychiatry at the University of Cambridge, combined careers as a neuropsychiatrist and historian. His conceptual histories of psychiatric nosology included disorders related to ageing mainly in the nineteenth and early twentieth centuries. Despite including 'old age' in the titles of his research papers, they tended to focus on disorders considered 'involutional', i.e. mainly commencing around 45-50 years of age.³⁴ Jesse Ballenger, who skilfully dissected the history of Alzheimer's disease in the USA, worked as a nurse for older people, which inspired his subsequent research.³⁵ In his view, clinical understanding of dementia in the USA

³⁰ Tom Arie, Anthony Isaacs, 'The development of psychiatric services for the elderly in Britain' 241-261. In: *Studies in Geriatric Psychiatry* ed. Anthony Isaacs, Felix Post (Chichester: John Wiley and Sons, 1978); Tom Arie, David Jolley, 'Psychogeriatrics' 260-265. In: *A Century of Psychiatry* ed. Hugh Freeman (London: Mosby-Wolfe, 1999); Claire Hilton, 'The clinical psychiatry of late life in Britain from 1950 to 1970: an overview' *International Journal of Geriatric Psychiatry (IJGP)* (2005) 20: 423-428; Claire Hilton, 'The origins of old age psychiatry in Britain in the 1940s' *HoP* (2005) 16: 267-289; Claire Hilton, 'The provision of mental health services for people over 65 years of age in England 1970-78' *HoP* (2008) 19: 297-320

³¹ Arie and Isaacs, 'Development' 251

³² Roy Porter, 'Dementia' 52-62. In: *A History of Clinical Psychiatry: the origin and history of psychiatric disorders* ed. German Berrios, Roy Porter (London: Athlone Press, 1995)

³³ Scull, 'Psychiatry and its historians' 239

³⁴ e.g. German Berrios, 'Affective disorders in old age: a conceptual history' *IJGP* (1991) 6: 337-346; Felix Post, *The Clinical Psychiatry of Late Life* (London: Pergamon Press, 1965) 103

³⁵ Jesse Ballenger, *Self, Senility, and Alzheimer's Disease in Modern America: a history* (Baltimore: Johns Hopkins University Press, 2006) ix

developed from a psychological foundation, contrasting with the more biological British approach.³⁶ The massive asylums, the extent of private psychiatric practice³⁷ and lack of state-provided health and welfare services in the USA³⁸ probably put Britain ahead of the USA in developing psychogeriatric services.³⁹

Historical investigation of psychogeriatrics followed a pattern similar to that of its clinical practice. Psychogeriatrics emerged at the interface of psychiatry and geriatric medicine, but authorities responsible for providing these 'parent' services often overlooked the mental wellbeing of older people. Similarly, historians have overlooked psychogeriatrics, while the history of psychiatry mainly concerning younger people is relatively well researched,⁴⁰ and there is an increasing body of historiography on geriatric medicine.⁴¹

Few historians have considered older people from any perspective. Reasons for the absence of old age from medical historiography are unclear but perhaps reflect lack of interest, a bias of editors or the marginalisation of older people in society generally. Webster noted:

Considering the importance of the elderly as users of the NHS, remarkably little retrospective analysis has been written about the health services from their perspective.⁴²

³⁶ *Ibid.* 47-55

³⁷ Edward Shorter, *A History of Psychiatry: from the era of the asylum to the age of Prozac* (New York: John Wiley, 1997) 190-191

³⁸ Peter Rabins, 'The history of psychogeriatrics in the United States' *International Psychogeriatrics* (1999) 11: 371-373

³⁹ Kenneth Shulman, 'The future of geriatric psychiatry' *Canadian Journal of Psychiatry* (1994) 39: 8 Supplement 1: S4-S8

⁴⁰ Shorter, *History of Psychiatry*; Edward Shorter, David Healy, *Shock Therapy: a history of electroconvulsive treatment in mental illness* (New Brunswick: Rutgers University Press, c.2007); Andrew Scull, *Decarceration: community treatment and the deviant – a radical view* (Cambridge: Polity Press, 1984)

⁴¹ Michael Denham, 'The history of geriatric medicine and hospital care of the elderly in England between 1929 and the 1970s' (PhD Thesis, University College London, 2004); Thane, *Old Age*, 436-457

⁴² Webster, 'The elderly' 165

Concerning psychogeriatrics, clinical provision and studies by historians may also have been inhibited by lack of clarity about older people's mental disorders and where they belonged on a spectrum across psychiatry, geriatric medicine, social welfare and normal ageing, together with a tendency to regard older people with mental disorders, as one psychogeriatrician put it:

with the same affection as nettles. Viewed *en masse* they may not be beautiful, examined as individuals initial interest may be diminished by lingering discomfort.⁴³

Tom Kitwood, a psychologist, reflected, in a historical study, on a pervasive pessimism in the 1980s around 'senility',⁴⁴ a pejorative term at that time. Negative associations with the all encompassing label of senility might have contributed to neglect of the topic by historians by de-humanising the condition and the suffering caused by it. Historians might also have considered age irrelevant to psychiatry, as many psychiatrists did, taking the 'colour-blind' or age inclusive approach that everyone was the same, and thus ignoring real differences. It is rare to find case studies, or reference to disorders commonly affecting older people, included in historical studies supposedly encompassing all adult age groups. The *Journal of the History of the Neurosciences* includes neuropsychiatry, of which dementia is part. However, the journal has – up to 2013 – published little relevant to disorders associated with old age. Another journal, *History of Psychiatry*, produced a 'special issue' in 2012 on 'dying insane in Britain' before 1940, but it hardly mentioned the predicament of many older people dying in asylums.⁴⁵

Shulamit Ramon, who reviewed British policies on psychiatry from the 1920s to the 1950s, remarked that, since older people were a large group of mental hospital in-patients, their needs 'deserved attention',⁴⁶ but then ignored them.

⁴³ David Jolley, 'Psychiatrist into psychogeriatrician' *News and Notes* (NN) (of the RCPsych) (Nov. 1976) 11-13 11

⁴⁴ Tom Kitwood, 'Dementia' 63-71. In: *History of Clinical Psychiatry* ed. Berrios and Porter, 67

⁴⁵ Jonathan Andrews (ed.) *Lunacy's last rites: dying insane in Britain, c. 1629-1939*. HoP (2012) 23:

⁴⁶ Shulamit Ramon, *Psychiatry in Britain: meaning and policy* (London: Tavistock, 1985) 185

Historian John Welshman similarly acknowledged, then excluded, older people from his study of mental hospitals and community care.⁴⁷ Inadequate official age-related data might partly have accounted for omitting them, although other sources would have made older people's presence obvious. Their fleeting remarks, divorced from the details, hint at not knowing how best to analyse historically services for older mentally unwell people. This resembled patterns of response by some clinicians,⁴⁸ unsure of how best to provide services for them.

Porter ignored mental disorders in older people in his broad histories of psychiatry. In *Madness: a brief history* he asked who was identified as mad, what caused their condition and what was done to 'cure or secure them';⁴⁹ older people were not part of his answers. Porter also wrote specifically on the history of dementia. He noted, oddly, 'the new nineteenth-century involvement with psychogeriatrics'.⁵⁰ What he meant is unclear: in the nineteenth century the term 'psychiatry' was hardly used in England, and 'geriatrics' had not been coined. He commented on 'fierce internal and professional struggles' over whether senile dementia was caused by ageing or disease.⁵¹ His views were likely to have reflected the Alzheimer's disease research agenda in the USA and seemed out of place relative to pragmatic clinical concerns in Britain where arguments were more likely to be about who should take responsibility for providing services.⁵² Porter was also critical of the tendency to medicalise conditions:

⁴⁷ John Welshman, 'Rhetoric and reality: community care in England and Wales 1948-74' 204-226. In: *Outside the Walls of the Asylum: history of care in the community 1750-2000* ed. Bartlett Peter, Wright David (London: Athlone Press, 1999) 206

⁴⁸ Annie Altschul, 'Psychiatric Nursing in Great Britain' Second National Congress of Psychiatric Nursing, Madrid 1983 (Royal College of Nursing Archives, RCNA, C305/1/2)

⁴⁹ Roy Porter, *Madness: a brief history* (Oxford: OUP, 2002) 9

⁵⁰ Porter, 'Dementia' 57

⁵¹ *Ibid.* 60

⁵² Raymond Levy, interview by author (2009)

Once a problem – such as the psychiatric aspects of old age – is called a disease, in some senses it ceases to be part of the human condition and gets turned into a technicality.⁵³

One doubts if he would have classed physical illnesses such as cancer or heart disease as the ‘human condition’. Categorising mental disturbance in old age as part of normal health was highly subjective.

Psychiatrist Thomas Szasz devoted just four pages of his book *Coercion as Cure* to ‘geriatric psychiatry’.⁵⁴ Szasz agreed with Porter: depression was an understandable feature of old age, rather than a condition requiring remedy. He stated that treatment was ‘driven by psychopharmacology’⁵⁵ i.e. by the commercial pharmaceutical industry rather than by neuroscience or clinical understanding. In Szasz’s view, ‘The remedy for the “aged man” is meaning, not medication’.⁵⁶ Szasz was a proponent of the international anti-psychiatry movement which started in the early 1960s, advocating mainly on behalf of younger people suffering chronic or relapsing psychiatric disorders.⁵⁷ Anti-psychiatry abhorred labelling people as ill and preferred to explain mental disturbance as an individual’s response to a mad society, which was contrary to accumulating biological evidence.⁵⁸ Porter’s and Szasz’s conclusions about older people bear little relationship to discoveries about the pathology of dementia and the emergence, and demonstrated effectiveness, of multi-disciplinary psychogeriatric practice in England.⁵⁹

Historians writing specifically about older people such as Moira Martin, Pat Thane and Michael Denham, cannot be accused of ageism, but they largely ignored mental health. This is problematic since the impact of mental disorders

⁵³ Porter, ‘Dementia’ 61

⁵⁴ Thomas Szasz, *Coercion as Cure: a critical history of psychiatry* (New Jersey: Transaction Publishers, 2007) 199-202

⁵⁵ *Ibid.* 199

⁵⁶ *Ibid.* 202

⁵⁷ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford: OUP, 2005) 22

⁵⁸ Shorter, *History of Psychiatry*, 239-288

⁵⁹ Arie and Isaacs, ‘Development’

in old age is extremely broad: they are psychologically and socially disabling for the sufferer, can affect treatment for physical illnesses, often involve the patient's family and social network, and draw on personal financial resources and state welfare benefits. Although these factors might not have been widely acknowledged in the distant past, greater appreciation of their impact during the professional life times of contemporary historians makes their exclusion surprising. Thane, for example, wrote on 'inventing geriatric medicine' but did not similarly review its psychiatric counterpart.⁶⁰ In a comprehensive historical review of geriatrics in 1993, she mentioned the 'distinctive specialism of psychogeriatrics', but added almost nothing more about it.⁶¹ Like Ramon and Welshman, Thane acknowledged the need, but veered away from it. Thane was negative about some chronic disorders, including dementia: 'relatively little can be done ... except to be kept alive',⁶² ignoring the hallmark of psychogeriatrics – active physical, psychological and social interventions to improve quality of life even in the absence of a cure.⁶³ Denham's thesis, about the development of geriatrics in the mid-twentieth century, acknowledged the interaction between it and psychiatry, but did not expand on that relationship,⁶⁴ despite geriatric medicine constructively influencing clinical approaches to mental disorders in older people.⁶⁵ In a brief historical review of geriatric medicine, geriatricians Graham Mulley and Adam Barton acknowledged the need for close clinical liaison between geriatric medicine and psychogeriatrics, but space did not permit further elaboration.⁶⁶ Overall, mental health was left out because it was absent from the geriatric medicine sources on which the historians relied. It indicates a degree of marginalization of mental health within geriatric medicine.

⁶⁰ Thane, *Old Age*, 436-457

⁶¹ Thane, 'Geriatrics' 1108

⁶² *Ibid.* 1111

⁶³ Post, *Clinical Psychiatry*, 162

⁶⁴ Denham, 'Geriatric medicine' 368

⁶⁵ Tom Arie, 'The development in Britain' 9-11. In: *Principles and Practice of Geriatric Psychiatry* ed. John Copeland, Mohammed Abou-Saleh, Dan Blazer (Chichester: John Wiley and Sons Ltd, 2002) 9

⁶⁶ Alan Barton, Graham Mulley, 'History of the development of geriatric medicine in the UK' *Postgraduate Medical Journal* (2003) 79: 229-234 231

In 1989, medical sociologist Margot Jefferys edited a volume of essays based on a cluster of old age research studies which she had led, but it contained no contributions on mental wellbeing.⁶⁷ Two years later, her oral history study of the development of geriatric medicine included psychogeriatricians discussing their specialty and its interface with geriatric medicine, and geriatricians speaking about mental health.⁶⁸ Peter Jefferys, her son, a psychogeriatrician, commented that, despite the absence of a relevant contribution to her book, her interest in psychogeriatrics was long standing; she had influenced his choice of medical student elective attachment in 1969 to the brand new psychogeriatric unit at Goodmayes Hospital, Ilford.⁶⁹ It seems likely that no mental health proposals were submitted for Jefferys' book because no-one was interested in researching the subject.⁷⁰

Historical and sociological analyses of mental hospital closures largely omitted the impact on older people.⁷¹ Mentions of older people tended to be negative, e.g. labelling them as 'difficult to discharge',⁷² which might have been a simple statement of fact, but might also have reflected defeatist attitudes to their rehabilitation. Sometimes older people were described in disparaging and antiquated terms, such as Scull's use of 'aged insane'.⁷³ Use of negative or outdated language accompanied lack of serious attention to older people by historians. The small amount of historical study of treating mental disorders in old age reveals mainly negative views, emphasising that little could be done to help sufferers. It sheds light on the biases which might arise in investigating

⁶⁷ Margot Jefferys (ed.) *Growing Old in the Twentieth Century* (London: Routledge, 1989)

⁶⁸ Margot Jefferys (project leader) *The Oral History of Geriatrics as a Medical Speciality*. (British Library Sound Archives, BLSA, C512, 1991)

⁶⁹ Peter Jefferys, e-mail, 12.4.2012

⁷⁰ Pat Thane, e-mail, 26.1.14

⁷¹ Shorter, *History of Psychiatry*; Scull, *Decarceration*; Peter Barham, *Closing the Asylum: the mental patient in modern society* (London: Penguin Books, 1997)

⁷² Kathleen Jones, *Asylums and After: a revised history of the mental health services: from the early 18th century to the 1990s* (London: Athlone Press, 1993) 188

⁷³ Scull, *Decarceration*, 150

the history of psychogeriatric services, but provides little insight into their development.

Terminology

Several terms need clear definitions for the purpose of this research. Those occurring throughout the thesis are explained here, others are discussed as they arise in the text. Clinical terms are defined and explained in the hope that this study will be of interest to non-clinicians.

Psychiatry and psychogeriatrics

‘Psychiatry’ or ‘mental health’ is the branch of medicine treating mental illness, encompassing the range of professions and services involved in that process. Psychiatrists are medically trained doctors concerned with diagnosing and treating pathological mental syndromes which are usually severe, or likely to become so. They may have special expertise in different fields such as child, forensic, or old age psychiatry.

Referring to the emerging specialty, ‘old age psychiatry’ and ‘psychogeriatrics’ were used interchangeably during the period investigated in this study. There was discussion, but no decision, about which should be the official term.⁷⁴ ‘Psychiatry of old age’ was used from 1973 in the name of the special interest group of the RCPsych.⁷⁵ Confusingly, sometimes ‘psycho-geriatric’ was used specifically to mean collaboration between geriatricians and psychiatrists.⁷⁶ Other meanings included use of the term to refer to older people who were confused, with dementia or delirium, or those suffering from both mental and physical disease.⁷⁷ In this study, these uses only appear in quoted passages.

⁷⁴ DHSS discussion paper, ‘Manpower priorities: mental illness special interests’ 17.10.1975, 1 (The National Archives (TNA), MH 150/812); Tom Arie, ‘Enough knowledge to be out of danger?’ 2-4. In: *Recent Advances in Psychogeriatrics* (No. 1) ed. Tom Arie (Edinburgh: Churchill Livingstone, 1985) 4

⁷⁵ Pages 205, 235-236

⁷⁶ DHSS, *Psycho-Geriatric Assessment Units* HM (70)11 (London: HMSO, 1970)

⁷⁷ Tony (Anthony) Whitehead, ‘Book review’ [Brice Pitt, *Psychogeriatrics: an introduction to the psychiatry of old age* (Edinburgh: Churchill Livingstone, 1974)] *Age and Ageing* (Age Ageing) (1976) 5: 63

The North American term ‘geriatric psychiatry’ was used infrequently in the United Kingdom (UK).

The term ‘specialty’ is used to identify the development of psychogeriatric clinical expertise, knowledge and dedicated services although the specialty did not officially exist until 1989. Psychogeriatrics was its official title in 1989, changing to old age psychiatry the following year.⁷⁸ Sometimes, the terms ‘specialty’ and ‘sub-specialty’ were used vaguely and interchangeably; the latter is retained only in quotations.

Clinical and service provision terminology

The shifting terminology of psychiatric disorders can make historical investigation difficult. Medical terminology may change as understanding alters, but changes may be more rapid for stigmatised conditions due to attempts to enhance social acceptability. Many terms derived from previously standard medical vocabulary, for example ‘spastic’ or ‘mongol’, were defined as abusive during the period investigated in this study and have remained so. In relation to psychogeriatrics, it is no longer regarded as respectful to use the term ‘senile dementia’, to describe a person as a ‘dement’, or to refer to ‘the elderly’.⁷⁹ Antiquated terms have been used at times in this thesis where it was appropriate to use the language of the period in question, such as ‘mental deficiency’, ‘mental sub-normality’ and ‘mental handicap’ rather than ‘learning disability’.

Through most of the twentieth century, psychiatric disorders were ascribed to two categories: ‘functional’ and ‘organic’. These terms are appropriate historically for the period investigated. Functional disorders comprise those where the brain appears normal when examined by dissection or microscopically. They include schizophrenia and the ‘affective’ or ‘mood related’ disorders, depressive illness (‘depression’) and bipolar disorder (‘manic-depression’). Recent discoveries have revealed physical brain changes

⁷⁸ Manpower Committee, minutes, 14.2.1990, 4 (Royal College of Psychiatrists Archives, RCPsychA)

⁷⁹ Bernard Isaacs, ‘Let’s abolish “the elderly”’ *BMJ* (1982) 284: 112

occurring in functional disorders and some psychiatrists consider the functional/organic divide obsolete. However, importantly for planning and providing psychogeriatric services,⁸⁰ organic and functional disorders have different symptom clusters, needs and prognoses.

Chronic organic disorders include dementia ('chronic confusion') which is usually irreversible. Dementia is a generic term encompassing several disorders including Alzheimer's disease. Alzheimer's was thought to be a rare condition of younger people, synonymous with 'pre-senile dementia' and separate from 'senile dementia', until they were identified as pathologically identical in the 1960s.⁸¹ Until the 1960s, understanding of dementia in old age was complicated by uncertainty about its aetiology: ageing or pathology? Consequently, the terms 'disorder' or 'condition' rather than 'illness' have been used through much of this study. Other terms which appeared in older literature, such as 'dementia praecox' and 'syphilitic dementia' ('general paralysis') were virtually obsolete by the 1950s. The term 'psychosis' signified severe organic and functional disorders with various psychiatric symptoms.

Organic psychiatric disorders must be distinguished from 'physical' (medical and surgical) disorders which affect the body rather than mental processes directly. Delirium, an acute, often reversible, organic confusional state, may be precipitated by physical illness in older people. Sometimes, by the 1940s, this diagnosis was recognised as distinct from 'senile dementia', but this was inconsistent.⁸²

There is often a fine line between psychologically normal mental experiences and potentially severe psychopathological symptoms. For example, low mood (feeling depressed or miserable) may be a normal, self limiting emotional response, such as after bereavement, and does not require specialist treatment. This contrasts with the distress of depressive illness, a defined group of

⁸⁰ Faculty of the Psychiatry of Old Age, *In-patient Care for Older People within Mental Health Services* (London: RCPsych, 2011) 10, 12

⁸¹ JAN (Nick) Corsellis, *Mental Illness and the Ageing Brain* (London: OUP, 1962)

⁸² Anon. 'Mens sana' *Medical Press* (1940) 203: 297

symptoms which can be disabling or life threatening. Lapses of memory are normal, hence the existence of diaries, shopping lists and address books. Memory loss is not synonymous with dementia, but distinguishing between normal and abnormal forgetfulness can be difficult and may require specific skills.

Until the mid-1950s, in contrast to the case of younger people, psychiatric symptoms, including low mood, anxiety, hallucinations and delusions, when observed in old age, were usually attributed to 'senile dementia'. Even when extreme they were rarely identified as symptoms of psychiatric illness requiring treatment. It is difficult to find mental hospital accounts illustrating this, in part because of the 100 year closure rule for clinical archives.⁸³ A few case studies appeared in textbooks of psychiatry.⁸⁴ Occasionally, the press illustrated the diagnostic problem, for example, when legal consequences were associated with the mental condition. One report concerned an 80 year old woman in a workhouse in 1913 who died unexpectedly; the report stated that she had been treated for 'senile dementia'. However, that seems an improbable diagnosis: she broke her hip while at work.⁸⁵ Holding down a job was unlikely if she had dementia severe enough to cause death; she probably suffered an acute delirium. It is likely that the diagnosis of dementia was wrongly assumed because of her age. Another newspaper account in 1914 of an 'Aged woman's murder of her husband' commented: 'Medical evidence showed that the prisoner was suffering from senile dementia, but knew what she was doing'.⁸⁶ If she knew what she was doing, her actions were unlikely to have been caused by senile dementia. Media representations risked informing society that dementia was characterised by disturbed or dangerous behaviour, shifting public attitudes away from treatment, care and support towards secure containment such as in a mental hospital. The press was not the only source of public information, but

⁸³ TNA, *Hospital Records Database*, <http://www.nationalarchives.gov.uk/aboutapps/hospitalrecords/default.htm> accessed 15.1.2013

⁸⁴ e.g. Emil Kraepelin, *Lectures on Clinical Psychiatry* (1901) ed. Thomas Johnstone (London: Baillière, Tindall and Cox, 1904) 221-230

⁸⁵ Anon. 'Death in Withington workhouse: inquiry by Guardians asked for' *Guardian*, 28.6.1913, 5

⁸⁶ Anon. 'Aged woman's murder of her husband' *Times*, 8.7.1914, 4

with little clinical understanding of, or advocacy for, older people with mental disorders, such reports could promote misconceptions and create negative stereotypes and expectations which could become embedded in professional and public culture.

‘Treatment’ and ‘care’ also require definition. ‘Treatment’ implies active intervention to ameliorate symptoms. Psychiatric treatment has usually comprised physical interventions, such as medication or electro-convulsive therapy, augmented by social and psychological treatments. ‘Care’ is more ambiguous. It could mean passive nursing, such as in institutional accommodation, or it might encompass treatment, such as ‘community care’, a term which evolved without a clear definition. Where possible, ‘care’ is used here to indicate passive support and ‘treatment’ to indicate active, ameliorative intervention, while retaining the distinctive meanings of compound terms like community care. ‘Community care’ could be ambiguous: in the 1980s, it sometimes meant any provision outside hospitals and thus residential and nursing homes might be considered part of it.⁸⁷ Alternatively, it was used to refer only to provision for people living in their own homes.⁸⁸ This had implications for policy making.⁸⁹

Particularly before the 1960s, another poorly defined but widely used term was ‘chronic sick’. Most in that category were older people. Chronic sick patients who could not be cared for by their relatives and friends were likely to be nursed in chronic sick wards or in mental hospitals. ‘Chronic sick’ is used in this thesis where no more precise term is available.

The Local Government Act 1929⁹⁰ renamed workhouses and their infirmaries as ‘public assistance institutions’ and ‘municipal hospitals’. The Mental

⁸⁷ National Demonstration Services in Rehabilitation, ‘*Community Care: agenda for action: a response*’ *Psychiatric Bulletin* (1989) 13: 538-541 541

⁸⁸ Audit Commission, *Making a Reality of Community Care* (London: HMSO, 1986) 10

⁸⁹ Chapter 4

⁹⁰ Local Government Act 1929, 19 and 20 Geo 5, chapter 17

Treatment Act (MTA) 1930⁹¹ renamed asylums as ‘mental hospitals’ and the Mental Health Act (MHA) 1959⁹² renamed them as ‘psychiatric hospitals’ or just ‘hospitals’.⁹³ Like changing the names of stigmatising psychiatric disorders, renaming buildings did not alleviate the stigma or fear associated with them; nor did it rapidly change attitudes of society or staff. The new names tended to acquire the old stigma. Porter commented that the workhouse was ‘the forerunner (and all too often the prototype) of the old people’s home or geriatric ward’.⁹⁴ In 1989, 60 years after Chorlton Union Workhouse, South Manchester, officially became Withington Hospital, while working in psychogeriatrics I visited, at home, an extremely forgetful patient. At her front door I told her that I was from the hospital. She told me to leave since she did not like people from the workhouse. Suffering from poor short term memory, she asked again: ‘Who are you?’ and I replied: ‘I am from an organisation which likes to help elderly people to stay at home’. Smiling, she invited me in. This illustrates long-standing, deeply embedded anxieties about institutions that were formerly workhouses. Similar observations have been highlighted by other clinicians⁹⁵, social scientists and historians.⁹⁶

For long-stay care provision, terminology remained the same but its meaning changed. At the inception of the post-war welfare state, residential homes, mainly provided by local authorities or voluntary organisations on a means tested basis, offered social care to people who could not manage daily tasks necessary for living independently at home, such as shopping, cooking, laundry and cleaning. By contrast, nursing homes were for people who required personal physical care. They were run privately or by voluntary organisations

⁹¹ Mental Treatment Act 1930, 20 and 21 Geo 5, chapter 23

⁹² Mental Health Act 1959, 7 and 8 Eliz 2, chapter 72

⁹³ Martin, *Adventure*, viii

⁹⁴ Porter, ‘Dementia’ 53

⁹⁵ Mohan Kataria, ‘Conversion of St Francis’ c.1970 (British Geriatrics Society Archives, BGSA)

⁹⁶ MA Crowther, *The Workhouse System, 1834-1929: the history of an English social institution* (London: Methuen, 1983) 7

for those who could afford to pay.⁹⁷ For those requiring nursing care who could not afford the fees, the alternative was long-stay hospital care which was provided free of charge. The mental hospitals provided for many older people who were generally perceived as ‘senile’, with and without behavioural problems. Geriatric or chronic sick wards provided for those with chronic physical illness or diagnosed with ‘senility’ plus reduced mobility. This NHS provision diminished when mental hospitals and geriatric wards closed. Privately run residential and nursing homes gradually replaced them, encouraged by the Conservative government in the 1980s and funded by means tested social security benefits. They filled with increasingly dependent people, often with dementia, similar to those previously nursed in long-stay hospital wards, vastly different from their residents 40 years earlier.

Caution should be exercised in interpreting some apparently straightforward terminology. For example, in the 1980s government publications concerning service provision used ‘adult’ in two ways: to include old age,⁹⁸ or only people upto 65 years.⁹⁹ The latter could imply, pejoratively, that older people were no longer considered adult. If unspecified in official documents, ‘adult’ could be open to interpretation as either inclusive or exclusive of old age, providing a loophole through which to avoid responsibility for older people. This thesis endeavours to avoid the term ‘adult’, preferring where possible to establish chronological age.

Some other terminology changed over the years, such as the title of the government body responsible for health services: Ministry of Health (MoH) 1919-68; Department of Health and Social Security (DHSS) 1968-88; Department of Health (DoH) since 1988.

⁹⁷ Sheila Peace, ‘The development of residential and nursing home care in the United Kingdom’ 15-42. In: *End of Life in Care Homes: a palliative approach* ed. Jeanne Katz, Sheila Peace (Oxford: OUP, 2003)

⁹⁸ Roy Griffiths, *Community Care: agenda for action* (London: HMSO, 1988) 3

⁹⁹ House of Commons Social Services Select Committee, *Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People* Vol. 1 (London: HMSO, 1985) ix

Two further uses of terminology are worth explaining as they occur frequently. The term ‘carer’ is used to mean relatives and friends, often living in the same household, informally providing regular support to enable an older person to remain at home. This term is not used to refer to formally employed staff, either in institutions or in the community. The term ‘scientific’ may also be ambiguous. Scientific research refers to investigations carried out to elucidate pathological features and mechanisms of disease. Clinical research focuses on assessing and treating patients, although these studies are also conducted using scientific methodology.

Setting the research frame

Time

To identify a precise date or a single event for the origins of psychogeriatrics, and thus the present investigation, is unrealistic. Various events and contextualising factors suggest c.1940 as a reasonable start date. Until Dr Marjory Warren (1897-1960) commenced her work with older people in 1935¹⁰⁰ there was virtually no recorded attempt in Britain at restoring health to older people suffering physical or mental disorders. Positive ideas about clinical interventions for older people appeared occasionally in the medical literature in the second half of the 1930s.¹⁰¹

In 1939, in order to free hospital beds to treat anticipated war casualties in urban environments, many chronic sick patients were discharged or transferred to accommodation in rural areas. Many were older people with mental and physical disabilities. In this context, Dr Lionel Cosin (1910-94), a hospital medical superintendent, was inspired to look for ways of improving their health. Apart from Warren and Cosin, interest was sparse.¹⁰²

Warren’s early work, of which she wrote an account in 1943, was a turning point in medical understanding that older, physically unwell people could

¹⁰⁰ Denham, ‘Geriatric medicine’ 40

¹⁰¹ e.g. Anon. ‘Surgery in old age’ *Lancet* (1937) i: 1182; Anon. ‘Surgery in old age’ *Lancet* (1939) i: 1210-1211

¹⁰² Thane, *Old Age*, 439

recover and that a specialty of geriatric medicine could be a reality.¹⁰³ The first identified reports that older, mentally unwell people could be discharged from hospital appeared around the same time.¹⁰⁴ Other factors contributed to preparing the ground to develop psychiatric services generally, including the rise of Nazism which drove refugee psychiatrists of international stature to Britain.¹⁰⁵ Plans for post-war reconstruction, including a universalist welfare state with free health care for all, had the potential to impact on the wellbeing of older people.

Determining a date to conclude this thesis is clearer: 1989. In that year, psychogeriatrics was recognised by the Department of Health as a distinct medical specialty. As a result, health authorities collected specific data on psychogeriatric services,¹⁰⁶ with implications for resourcing and monitoring services and training specialists.¹⁰⁷ This was a significant landmark.

Place

Of necessity, the research is restricted to England, rather than the UK, for two main reasons. Although most government health service planning covered England and Wales, services in Wales developed differently, at times under separate government directives.¹⁰⁸ This was reflected in 1985/6 by findings of significantly lower *per capita* provision of psychogeriatric services in Wales compared with elsewhere in the UK.¹⁰⁹ Secondly, the NHS in Scotland and Northern Ireland functioned independently from the NHS in England, making

¹⁰³ J Grimley Evans, 'Service and research for an ageing population' *Age Ageing* (2000) 29: Supplement 1: 5-8 5

¹⁰⁴ Aubrey Lewis, Helen Goldschmidt, 'Social causes for admission to a mental hospital for the aged' *Sociological Review* (1943) 35: 86-98; Felix Post, 'Some problems arising from a study of mental patients over the age of 60 years' *JMS* (1944) 90: 554-565

¹⁰⁵ John Cooper, *Pride versus Prejudice: Jewish doctors and lawyers in England 1890-1990* (Oxford: Littmann, 2003) 208

¹⁰⁶ Manpower Committee, minutes, 14.2.1990, 4 (RCPsychA)

¹⁰⁷ Royal College of Physicians of London (RCP)/RCPsych, *Care of Elderly People with Mental Illness: specialist services and medical training* (London: RCP/RCPsych, 1989) 21-22

¹⁰⁸ RCPsych, 'Comments on *Proposed all-Wales Policies and Priorities for the Planning and Provision of Health and Social Services from 1976/77 to 1979/80* (Welsh Office, 1976)' RCPsych, EFCC15/76A C32/76A (TNA, MH 154/935)

¹⁰⁹ John Wattis, 'Geographical variations in the provision of psychiatric services for old people' *Age Ageing* (1988) 17: 171-180 172, 175

generalisations difficult. In Scotland, geriatric and psychogeriatric services developed alongside, or even shortly before,¹¹⁰ those in England. Developments in Scotland, Wales and Northern Ireland will be referred to from the perspective of their relationship with, and influence on, psychogeriatrics in England.

Population and services

There were some differences in the populations who might have made use of the various health and social care resources. In the period since 1948, this study relates to almost the entire population who might seek diagnosis, treatment and health care, as almost everyone was eligible for free NHS services. For the social aspects of care, it relates to those people, generally with lesser private means, who sought care from means tested public welfare resources. This study is primarily about health services but inevitably it overlaps with social care services. The various services ideally dovetail and complement each other in order to provide for a broad spectrum of needs.

Method

Berrios identified two viewpoints from which to explore history of mental disorders: 'internalist' and 'externalist'. The internalist approach concentrates on the origin of the scientific language and psychiatric concepts. The externalist explores the social and political variables which have influenced attitudes towards abnormal behaviour, and the professionalisation of those charged with the care of mentally unwell people.¹¹¹ Both contribute to understanding the development of psychiatric services, the study of which comprises a third viewpoint, the empirical.

This study combines social, political and medical history. Its approach is 'bottom-up' and 'top-down', exploring the daily work of NHS staff and the politics and policies of government. The effects of government policies are

¹¹⁰ e.g. Scottish Home and Health Department, (SHHD) Scottish Health Services Council, *Services for the Elderly with Mental Disorder* (Millar Report) (Edinburgh: HMSO, 1970)

¹¹¹ German Berrios, 'A conceptual history in the nineteenth century' 3-5. In: *Principles and Practice* ed. Copeland *et al.* 3

crucial in a study of health service development. This thesis concentrates on the interface between government policy and administration and NHS implementation, rather than on the interactions between tiers of policy makers in government which might have indicated their reasoning for facilitating or restricting the development of dedicated psychogeriatric services. Analyses of this kind would have added an additional layer of explanation for policies and recommendations which were sometimes experienced as problematic by those trying to develop services. However, systematic data collection for this thesis was completed in 2011, when the ‘30 year rule’ for accessing government archives was still in full operation and prevented ready access to documents of the 1980s. Research into the complexities of government policy making was also constrained by the time permitted and space available for a PhD. Analysis of governmental policy making concerning psychiatric services for older people remains a necessary and desirable future project.

Archives

Since psychogeriatrics did not exist officially as a specialty before 1989, and terminology varied, sometimes it was difficult to locate documents in the catalogues of larger archive collections. This was especially challenging at the National Archives (TNA) (Table 1)¹¹² where a ‘needle in haystack’ method was required. It also impeded potential Freedom of Information (FoI) requests relating to the 1980s which require knowledge of specific documents to be requested.

¹¹² Table 1. TNA catalogue, code MH: ‘relating to provision of health and public health services’

Search term	Number of items
Mental health	>1,000
Psychiatry	38
Care of the elderly	101
Chronic sick	67
Geriatric	31
Elderly mentally ill	10
Elderly mentally infirm	7
Old age psychiatry	0
Psychogeriatric	3
Psycho-geriatric	1

Generous access to personal archives in part compensated for lack of government archives, by providing a rich source of correspondence and minutes of meetings with government, local management, voluntary bodies, and medical Royal Colleges. Personal and institutional archives revealed discussion and disagreements which often contrasted with the published, or officially minuted, consensus.

Archives are not free from bias: those preserved for both public and private use may be selective. In particular, RCPsych archives relating to various College activities, including the development of the psychiatric specialties, had been ‘weeded’ because of lack of storage space.¹¹³ Consequently, minutes of meetings are often devoid of their supporting documents which can cause problems for interpreting those minutes.

Published sources

Academic medical journals provided essential material for this study. Psychogeriatricians valued achieving publications in these, acknowledging the ‘legitimising value of print’.¹¹⁴ However, journal articles are not value free and may be subject to bias. Editorial preference, peer review and the tendency to publish positive over negative results could influence chances of publication. Medical journals characteristically contain numerous brief reports, a recognised challenge for contemporary medical history,¹¹⁵ partly because it necessitates extensive referencing. For all sources, the sampling frame was expanded by following up leads, such as in footnotes and references, and names of authors and institutions.

Research papers were crucial to revealing the scientific and clinical foundations and effectiveness of the specialty. Papers have been judged by the standards of

¹¹³ Francis Maunze, archivist, RCPsych, discussion 12.11.2012

¹¹⁴ Tom Arie, In: Guthrie Trust Witness Seminar 2008 (‘Witness’), *The Development of Old Age Psychiatry in Britain 1960-1989* ed. Claire Hilton (2009) 47
www.gla.ac.uk/media/media_196526_en.pdf accessed 11.6.2013

¹¹⁵ History of Modern Biomedicine Research Group, ‘What is a witness seminar’
<http://www.history.qmul.ac.uk/research/modbiomed/what-is-a-witness-seminar/index.html>
accessed 22.5.2012

the professional community for whom they were written rather than those current today. For example, much influential psychiatric research from the 1950s and 1960s lacked matched control groups for comparing different interventions,¹¹⁶ with the risk of drawing false conclusions. The importance of the publications lies in how they were interpreted by practitioners and those making decisions about psychogeriatric services at the time.

Editorials and opinion pieces revealed attitudes and concerns relating to the specialty. Through much of the period under study, medical journals routinely published editorials, reports and news items anonymously.

Journals specific to psychiatry and geriatric medicine or with a broad readership, such as the *Lancet* and *British Medical Journal (BMJ)*, were searched systematically using contents pages and indexes, either in hard copy or in electronic databases, depending upon availability. Nursing, psychology, social work and occupational therapy journals were searched, mainly page by page, taking one in six samples of monthly or bi-monthly journals, and one in ten for weekly periodicals. The sample size was increased if the yield was significant, but often nothing relevant to the care of older people was identified.

Informal psychiatry and psychology newsletters circulated to professionals were another valuable source of information. In particular, they contained reports on conferences and meetings and personal views often reflecting frustrations and successes.

Dates of publication of books and research papers do not necessarily identify the dates when they were influential. Medical research discussed by researchers before publication, at seminars, conferences and informal meetings, could influence practice by word of mouth. The pioneer psychogeriatricians, creating a low prestige specialty without dedicated funding, were necessarily resourceful and imaginative: an aside might generate thoughts and intuitive

¹¹⁶ e.g. Post, *Significance*

guesses based on experience of what might be clinically effective, triggering a change in service provision or a new study.

Browsing the shelves at the Wellcome Library, London, was a fruitful source of text books reflecting clinical practice taught to students of medicine and other professions in the formative years of their careers. Electronic key word searches were used for the *Times*, *Guardian* and *Observer* national newspapers to gain an impression of public concern, interest and opinion. Thematic searches of internet sources, particularly government and parliamentary databases, revealed much information, as did searches for individuals in the *Oxford Dictionary of National Biography*. The reliability of websites was considered for each one consulted. Sites containing full text digitised (rather than transcribed) documents, such as WHO, TNA, newspapers, some government sources and the Nuffield Provincial Hospitals Trust (NPHT – aiming to promote analysis and informed debate about UK health policy), were the most reliable for individual documents, although in some there was the possibility of selection bias regarding the documents to which access was permitted.

Numerical data

Lack of specialty recognition created problems for interpreting objective numerical data. Data were not collected with the needs of psychogeriatric service provision in mind. For example, they provided information about community facilities for ‘the elderly’ which were said to include people with mental frailty.¹¹⁷ Ministry of Health tables of psychiatric hospital activity rarely stated age group¹¹⁸ or provided an age breakdown over 65 years.¹¹⁹ Much data, such as about mental hospital and welfare service provision, were difficult to compare longitudinally, as collection over time was not uniform.

¹¹⁷ MoH, *Health and Welfare: the development of community care* (Revision to 1975-1976) (London: HMSO, 1966) 412

¹¹⁸ MoH, *The Activities of Psychiatric Hospitals: a regional comparison. Mental hospitals and units 1964* (Statistical Report Series No. 3) (London: HMSO, 1968) v-vi

¹¹⁹ DHSS, *The Facilities and Services of Psychiatric Hospitals in England and Wales 1971* (London: HMSO, 1973) 44

Data were collected for administrators, planners, and government departments, not for historians or researchers assessing long-term trends.

Oral

Psychogeriatricians working during the formative years of the specialty were keen to contribute personal memories of work, colleagues, research and service development. Oral history evidence is sometimes criticised as being too retrospective and open to re-interpretation and distortion. However, contemporaneously written documents are not immune from these biases. All sources need to be contextualised and used critically in the light of other sources. Written and oral evidence were combined in this study to validate individual memories using multiple sources to confirm or give alternative explanations.

Memory is a creative and constructive process, rather than a pure retrieval of information, and this has potential pitfalls for the historian. The content can be affected by the interviewer and interviewee's interests,¹²⁰ their relationship,¹²¹ the focus of the interview (e.g. whole life narrative or information seeking)¹²² and the skill of the interviewer.¹²³ Reliability of memory can be influenced by psychological factors such as hindsight,¹²⁴ the importance of the memory to the individual, or suppression of uncomfortable memories.¹²⁵ These factors may be relevant to the difficulty of obtaining oral histories from influential figures such as senior managers or clinicians, who, according to written sources, opposed the creation of the specialty. Some refused to be interviewed but gave realistic reasons, for example, that development of the specialty was only a minor part of their work and relatively unimportant to them years later: 'My memory for events at that time has faded', commented Elizabeth Shore, former deputy

¹²⁰ Paul Thompson, *The Voice of the Past* (Oxford: OUP, 2000) 157-158

¹²¹ *Ibid.* 140

¹²² *Ibid.* 227

¹²³ *Ibid.* 169, 223

¹²⁴ Paul Thompson with Rob Perks, *An Introduction to the use of Oral History in the History of Medicine* (London: British Library, 1993) 12

¹²⁵ Thompson, *Voice*, 169

Chief Medical Officer (CMO).¹²⁶ Involved clinicians spent much of their working lives creating, running and evaluating services, which is probably why they had vivid memories of events. This contrasted with other clinicians, civil servants and administrators who were only intermittently involved. Involved psychiatrists provided me with names of DHSS staff to contact, but they proved unfruitful. Lack of access to government archives during the 1980s further added to the difficulty of identifying involved civil servants in more recent years.

Three categories of oral history sources were used: interviews by the author, interviews by other people and a 'witness seminar'. Interviews bear out the observation that "Facts" were never plain and simple; they were layered with feelings, perceptions, ideology, and historical consciousness'.¹²⁷ Sometimes details of an event may be less significant than how the players interpreted it and how it affected their actions and interactions.

The author's individual, face-to-face interviews used a semi-structured format to facilitate analysis, while allowing interviewees to address their own agendas. Interviews combined a life history approach with a focus on professional work. The author recorded and transcribed six interviews with individual psychogeriatricians, a neuropsychiatrist, a geriatrician and a psychologist between 2004 and 2010.¹²⁸ Carrying out interviews early in research had the benefit that the interviewer had a high level of curiosity and low level of preconceived ideas thus making the interview as neutral as possible. A potential disadvantage was that some issues might have been inadequately covered because the interviewer was insufficiently informed about the context. With that in mind, two psychogeriatricians were re-interviewed. Other

¹²⁶ Elizabeth Shore, e-mail, 2011

¹²⁷ Jane Sherron De Hart, 'Oral sources and contemporary history: dispelling old assumptions' *Journal of American History* (1993) 80: 582-595 592

¹²⁸ Stephanie Kraus, Harrow Ethics Committee: 'The Chairman of the Committee is of the opinion that this study does not need to be presented for ethical approval' 24.6.2003

interviews, carried out in 2004 for a related study,¹²⁹ included nurses and a social worker. These failed to reveal additional useful information.

The majority of interviews by other researchers were from *The Oral History of Geriatrics as a Medical Speciality* (1991).¹³⁰ This collection comprises 73 audio-recorded interviews, mainly of geriatricians, but also of nurses, psychogeriatricians, social workers, politicians involved in health policy (Rt. Hon. Enoch Powell and Sir Kenneth Robinson) and a CMO (Sir George Godber).¹³¹ This resource was compiled by a team of expert, clinically uninvolved interviewers.

Witness seminars gather several people associated with a particular set of events to meet together to discuss their reminiscences. A standard format is followed: the meeting is chaired and invited key individuals make presentations which are followed by open discussion. The proceedings are audio-recorded and transcribed. Witness seminars have the advantage of open peer review: participants can challenge and correct each other to improve accuracy, and indicate shared or contrasting memories.¹³² I organised, in collaboration with Professors Tom Arie and Malcolm Nicolson,¹³³ a witness seminar on the development of psychogeriatrics. Of those invited, eleven psychogeriatricians and one geriatrician participated. All were NHS consultants before 1989.¹³⁴ Despite attempts to make it a multi-disciplinary event, to include nurses, psychologists, general practitioners and NHS managers, several were invited but none were able, or perhaps wanted, to attend.

¹²⁹ 'A biographical study of Felix Post 1913-2001', funded through a Wellcome Trust Leave Award in the History of Medicine, 2004

¹³⁰ Jefferys, *Oral History* (BLSA)

¹³¹ Enoch Powell, Kenneth Robinson, George Godber, interviews in *Oral History* (BLSA)

¹³² EM (Tilly) Tansey, 'The witness seminar technique in modern medical history' 279-295. In: *History of the Social Determinants of Health: global histories, contemporary debates* ed. Harold Cook, Sanjoy Bhattacharya, Anne Hardy (Hyderabad, India: Orient BlackSwan, 2008) 281

¹³³ 'Witness', seminar team, 1

¹³⁴ *Ibid.* List of speakers, 4

Other reflective personal sources

Autobiographical vignettes about the early careers of participants in the witness seminar, and about colleagues who could not attend, were published alongside the seminar transcript. They were notably modest, lacking self-publicity or grandiosity.¹³⁵

In 2010, I edited (with Professor David Jolley) a reflective, special issue of the RCPsych's Old Age Faculty newsletter, *Old Age Psychiatrist (OAP)*.¹³⁶ This commemorated 21 years since recognition of the specialty by the Department of Health. Contributions were requested and received from people in many disciplines who had experience of, or knowledge about, work with mentally unwell older people, including psychogeriatricians and other psychiatrists, geriatricians, nurses, social scientists, a carer, a psychologist, and an occupational therapist. However, similar to the difficulties encountered in trying to make the witness seminar multi-disciplinary, non-psychogeriatricians were less likely to contribute. The reasons they gave included insufficient previous involvement with the specialty or lack of expertise or authority. Nevertheless, the newsletter included personal testimony otherwise unavailable.

Other reflective material gathered from letters, e-mails and informal face-to-face or telephone conversations is included when considered trustworthy.

The patients' experience

Despite the desirability of including patients' experiences in a study of health service provision, it is almost impossible to construct a comprehensive picture in the present study. There are several reasons for this, including the 100 year closure rule.¹³⁷ Formal testimonials by patients, relatives and staff in connection with scandals about care, and nurses' accounts of their older

¹³⁵ 'Witness' 69-105

¹³⁶ Claire Hilton, David Jolley (guest editors) *OAP* (2011) 53:
<http://www.rcpsych.ac.uk/workinpsychiatry/faculties/oldage/aboutthefaculty/newsletters.aspx>
accessed 9.6.2013

¹³⁷ TNA, *Hospital Records Database*

patients' experiences,¹³⁸ give some insight but may emphasise the negative. Informal sources of information about patients' perspectives have been used where available and considered reliable. Very few patients of any age published or publicised their experiences of psychiatric treatment, and mentally ill older people might have lost the skills or the confidence to write, due to illness or institutionalisation, thus further minimising the chances of finding personal views. Creative literature tended to focus on the experiences of younger people.¹³⁹

From an oral history perspective, to interview any very elderly patients about their earlier illnesses or mental health service experiences over the age of 65 and before 1989, would require NHS ethics committee approval. Other proposed studies relating to psychiatric treatment in the distant past have not been granted approval on grounds of reviving difficult memories or risking revealing stigmatising mental illness, for example, if daily tasks such as answering telephone calls or opening letters were dealt with by relatives, carers or staff unaware of past illnesses.¹⁴⁰ An oral history project (2011-12) about the former psychiatric hospital at Shenley, Hertfordshire, was unable to capture directly any experiences of patients who were over 65 before 1989.¹⁴¹

Thesis structure

A chronological structure for analysis in the history of medicine is widely used to help unravel and clarify the complexities of policy and practice and enable contextualization in a wider health and social care framework.¹⁴² This is appropriate for the present study.

¹³⁸ Jane Brooks, "'The geriatric hospital felt like a backwater': aspects of older people's nursing in Britain, 1955-1980" *Journal of Clinical Nursing* (2009) 18: 2764-2772

¹²⁴ e.g. Ken Smith, Matthew Sweeny (ed.) *Beyond Bedlam: poems written out of mental distress* (London: Anvil Press, 1997)

¹⁴⁰ Ethics Committee, Northwick Park Hospital, 2002, concerning application to follow up the report by Eve Johnstone *et al.* 'The Northwick Park electroconvulsive therapy trial' *Lancet* (1980) ii: 1317-1320

¹⁴¹ Mind in Harrow, 'Hidden Minds', 2012. Discussion with Josie Hinton, project leader, Dec. 2012

¹⁴² Helen Lester, Jon Glasby, *Mental Health Policy and Practice* (London: Palgrave Macmillan, 2006) 17; Shorter, *History of Psychiatry*; Thane, *Old Age*

For the 1940s to 1960s the thesis explores the data decade by decade. These breaks were chosen because they are compatible with milestones in the development of the specialty. Themes within each chapter vary significantly. For example, in the 1940s, the work of the new geriatricians, the contributions to psychiatric modernisation by refugee psychiatrists from Nazi Europe and the creation of the NHS contrast with key themes in the 1960s such as societal views on autonomy, scandals of care, ‘misplacement’, anti-psychiatry and plans to modernise the NHS. Thus a ‘mosaic’ or ‘jigsaw’ like structure is used within each chapter.

In the 1970s and 1980s, psychogeriatric leadership and goals were more consistent, aiming to establish services nationally, provide specialist training for doctors and achieve official recognition. Thus the last two decades are analysed together, employing a more thematic, ‘time-line’ structure.

Chapter 1

First steps: rhetoric, resources and developments

*Spare me old age, let nature not decay
The physical and mental attributes I pride,
Let not the years dim youthful reason's ray
Lest by a rising generation, I be 'certified'.*

Nurse Kenneth Robertson, 1950¹

Introduction

Through much of the Second World War, but especially with new optimism after the victory at El Alamein in 1942, plans were being formulated to ensure the country would recover after the war. They included national health and social welfare structures.² Concerning health, the war time experiences of the Emergency Medical Service (EMS) demonstrated what might be achieved.³ The coordinated, regional structure of the EMS, providing well distributed acute hospital care throughout the country, was a prototype for a peace time health service.⁴

Social scientists and the government were concerned about demographic projections. More older people, combined with a low birth rate, created unease about their effect on the economy and how the country would provide for them.⁵ Ominous speculations surpassed the optimistic.⁶ An ageing population was viewed as a burden rather than an achievement to be celebrated.⁷ One frightening prediction was that by the end of the twentieth century the total UK

¹ Kenneth Robertson, 'Old folks "certified insane" to find them beds' *Forward*, 25.3.1950, 1

² William Beveridge, *Social Insurance and Allied Services* Cmd. 6404 (London: HMSO, 1942); MoH and Department of Health (DoH) for Scotland, *A National Health Service* Cmd. 6502 (London: HMSO, 1944)

³ Archibald Gray, Andrew Topping, *Hospital Survey: the hospital services of London and the surrounding area* (London: HMSO, 1945) 14

⁴ Charles Webster, *The National Health Service: a political history* (Oxford: OUP, 1998) 6-7

⁵ Richard Titmuss, *Poverty and Population: a factual study of contemporary social waste* (London: Macmillan and Co, 1938); Political and Economic Planning, *Population Policy in Great Britain* (London: PEP, 1948); *Report of the Royal Commission on Population* Cmd. 7695 (London: HMSO, 1949)

⁶ Pat Thane, 'The debate on the declining birth-rate in Britain: the "menace" of an ageing population, 1920s-1950s' *Continuity and Change* (1990) 5: 283-305 292

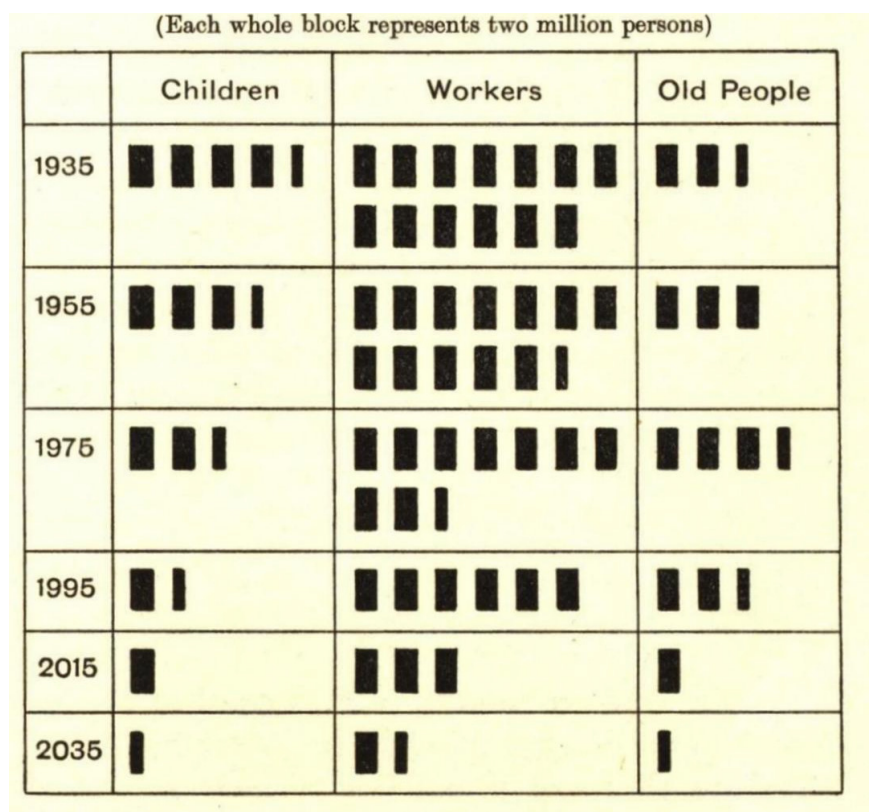
⁷ Thane, *Old Age*, 475, 479

population would fall (Fig 2). The Royal Commission on Population commented:

It is the fact that (with some exceptions) the old consume without producing which differentiates them from the active population and makes of them a factor reducing the average standard of living of the community.⁸

One medical journal commented that ‘All authorities agree that ... the beginning of a fall in birth-rate is the first sign of racial decay and death’.⁹ The demographic fears did little to encourage the government to make long-term plans for older people, but rather to focus on supporting families to raise more children.

Fig 2. ‘Trends in population’, 1935-2035



Source: Richard Titmuss, *Poverty and Population: a factual study of contemporary social waste* (London: Macmillan and Co, 1938) 9; (Reproduced with permission of Palgrave Macmillan. This material may not be copied or reproduced without permission from Palgrave Macmillan.)

⁸ *Report of the Royal Commission on Population*, 113

⁹ Anon. ‘The population problem’ *Medical Press* (1938) 197: 393-394 394

Denham, writing on the history of geriatric medicine, focussed his chapter on the 1940s largely on the work of a few individuals rather than taking a broader perspective.¹⁰ Other secondary historical sources about this period have much to say on welfare generally but little about old age health services, particularly mental health.¹¹ This chapter describes new ideas, policies and clinical interventions, mainly in the 1940s, which appeared likely to affect older mentally unwell people.

Clinical classification

In the 1940s, classification of disorders in old age was commonly based on readily observed symptoms rather than on an understanding of their aetiology and pathology. Symptoms were attributed to ageing rather than illness, ‘the result merely of senile changes’,¹² those ‘whose minds and bodies were wearing out unaccompanied by any specific disease’.¹³ This meant that symptoms were considered unavoidable, rather than as part of ameliorable, even if not curable, disorders. The labels of senility, senile dementia or senile psychosis implied clinical hopelessness.

Terminology was imprecise and some physicians recognised this difficulty.¹⁴ One physician, for example, diagnosed ‘senile dementia’ as either ‘uncomplicated’ or ‘complicated’, without further definition.¹⁵ Another used the categories ‘faculties slightly impaired’, ‘forgetful, childish – difficult to live with’ and ‘demented’.¹⁶ A social researcher commented vaguely on providing facilities for ‘Persons who are slightly senile but who are not senile dements’.¹⁷

¹⁰ Denham, ‘Geriatric medicine’ 71-109

¹¹ Thane, *Old Age*, 355-371, 438-452

¹² Central Health Services Council, Report of Mental Health Standing Advisory Committee (MH-SAC), 2.5.1949 Para 5 (TNA, MH 133/502)

¹³ V Hill cited in: Anon. ‘BMA Annual Meeting: summary of proceedings’ *BMJ* (1948) ii: 89-104 103

¹⁴ Aubrey Lewis, ‘Ageing and senility: a major problem of psychiatry’ *JMS* (1946) 92: 150-170 169

¹⁵ Lewis and Goldschmidt, ‘Social causes’ 87

¹⁶ Joseph Sheldon, *The Social Medicine of Old Age* (London: OUP, 1948) 107

¹⁷ B Seeböhm Rowntree, (Chair) *Old People: report of a survey committee on the problems of ageing and the care of old people* (London: Nuffield Foundation, 1947) 73

Public descriptions of old age mental disorder were also indistinct: ‘soft in the head’, ‘just a bit simple’, ‘childish’ or ‘unsound mind’.¹⁸ Similar terminology was used by professionals, as in a specialist mental health NHS advisory committee: ‘many ... are merely in their second childhood’.¹⁹ Vague definitions probably reflected lack of knowledge and could impair communication about the disorders which would hinder provision of potentially beneficial clinical and social interventions.

New classifications of the diverse mental and physical health needs of older people began to emerge. They encouraged active treatment and rehabilitation.²⁰ However, the medical profession retained a negative stance towards mental disorders in old age.²¹ This stance was probably more rigid than for mental disorders in younger people for whom new physical and psychotherapeutic treatments were offering ‘an atmosphere of therapeutic hopefulness’.²²

Improved systems of classification also highlighted that unwell older people frequently had multiple diagnoses, often mental and physical disorders simultaneously.²³ That contrasted with younger people, on whom treatment was generally focussed, who were more likely to suffer from a single condition. Older people’s health needs did not fit neatly into existing clinical expertise.

Treatment of older people with physical and mental disorders c.1940

Both old age and mental disturbance were categories deemed unworthy of attention in teaching hospitals. Prestigious hospitals avoided admitting older

¹⁸ BMA, *When You are Old* (London: BMA, 1949) 12, 18

¹⁹ MH-SAC, ‘Remit: Care of the aged’ (1949) Para 1 (TNA, MH 133/502)

²⁰ Marjory Warren, ‘Care of chronic sick’ *BMJ* (1943) ii: 822-823; BMA, *Care and Treatment*, 6; Post, ‘Some problems’ 561

²¹ Anon. ‘Mens sana’

²² William Sargant, Eliot Slater, *An Introduction to Physical Methods of Treatment in Psychiatry* (Edinburgh: Livingstone, 1944) 1

²³ Charles Andrews, ‘Early days in rural England’ *Modern Geriatrics* (1971) 1: 117-122 121

people who were usually assumed to be incurable.²⁴ The lack of psychiatric beds available in London undergraduate teaching hospitals – nine of 6,700 in 1938 – implied that psychiatry was not a respectable clinical subject.²⁵ It is therefore hardly surprising that work with mentally unwell older people was regarded with derision within the medical profession.

In the mid-1930s, for physical disorders in old age, some previously accepted beliefs were challenged in the UK medical press, such as the futility of surgical treatment for people of ‘advanced age’, generally over 70 years.²⁶ This contrasted with older people’s mental health which was noticeably absent from relevant medical journals such as the *BMJ*, *Lancet*, *Proceedings of the Royal Society of Medicine (PRSM)* and *Journal of Mental Science (JMS)*.²⁷

A paper in the *Lancet* in 1935 on common mental disorders mentioned ‘confusion’, but not in the context of old age.²⁸ Only treatment for younger people was discussed, although that type of confusion, or delirium, is more likely to occur in older than younger people. A book review of *Care of the Aged, the Dying and the Dead*²⁹ appeared in the *Lancet* the same year, ominously implying that physicians linked the three phases as a direct and predictable clinical progression. This book conveyed much good sense and compassionate care and remained in print for 40 years³⁰ but was unlikely to stimulate innovative treatment for older people. In 1939, the *Medical Press*, a journal for a broad medical readership, published a series of papers on ‘senile ailments’. One on mental disorders, written by Samuel Last (1902-91), a

²⁴ Lindsay Granshaw, ‘The rise of the modern hospital in Britain’ 197-218. In: *Medicine and Society: historical essays* ed. Andrew Wear (Cambridge: CUP, 1992) 202, 209

²⁵ Rosemary Stevens, *Medical Practice in Modern England: the impact of specialisation and state medicine* (New Haven: Yale University Press, 1966) 42

²⁶ Anon. ‘Surgery in old age’ *Lancet* (1937) i:1180-1181; Anon. ‘Surgery in old age’ *Lancet* (1939) i: 1210-1211

²⁷ Anon. ‘Editorial’ *BJPsych* (1963) 109: 1 *JMS* renamed (renamed *British Journal of Psychiatry* in 1963)

²⁸ Anon. ‘Some common mental disorders’ *Lancet* (1935) i: 327

²⁹ Anon. ‘Book review’ [Alfred Worcester, *Care of the Aged, the Dying and the Dead* (Springfield, Illinois: Thomas Books, 1935)] *Lancet* (1935) ii: 430

³⁰ Alfred Worcester, *Care of the Aged, the Dying and the Dead* (New York: Arno Press, 1977)

psychiatrist known for his progressive attitudes,³¹ implied little hope for older people. It suggested treating difficult behaviours by using sedatives, or ‘continuous baths’, and stated ‘The prognosis of all mental diseases of old age is bad ... no cure can be hoped for’.³²

Despite this pessimism, a pragmatic approach to rehabilitating physically ill older people began to develop in England. Marjory Warren took over the care of about 700 chronic sick patients at the West Middlesex County Hospital, a former workhouse infirmary, in 1935.³³ She was concerned about reluctance to admit older people to voluntary and teaching hospitals³⁴ because exclusion deprived them of modern medical facilities from which they might benefit. In 1940, an editorial in the *Medical Press*, described a retired man, physically ill and with disturbed behaviours probably due to delirium, who died following admission to a mental hospital when general hospital admission would have been more appropriate. It noted that:

There still exists in general hospital circles an emotional, traditional prejudice against a patient with any form of mental upset. All sympathy and desire to help seem to vanish. Nothing but irritation and an impatient desire to discharge the patient, regardless of effect ... exists.³⁵

Some older people died from illnesses which might have responded to treatment, while others accumulated, frequently undiagnosed and untreated, in less well equipped municipal and mental hospitals.

Normal medical practice was to put sick people to bed. It was not yet widely acknowledged that ‘beneath the comfort of the blanket there lurks a host of formidable dangers’.³⁶ More than half Warren’s new patients were bed ridden, which she attributed to passive, though dedicated, nursing care instead of active

³¹ David Watt, ‘Samuel Last’ *BMJ* (1991) 303: 577

³² Samuel Last, ‘Mental disorders in old age’ *Medical Press* (1939) 202: 329-332 331, 332

³³ Denham, ‘Geriatric medicine’ 40

³⁴ Warren, ‘Chronic sick’ 822

³⁵ Anon. ‘Mens sana’

³⁶ R Asher, ‘The dangers of going to bed’ *BMJ* (1947) ii: 967-968 967

treatment and rehabilitation.³⁷ Contrary to cultural beliefs emphasising inevitable decline in old age and trends which advocated rehabilitation only for young people, to make ‘the disabled person a functioning economic utility’,³⁸ Warren demonstrated that with age-appropriate specialist treatment much physical impairment in older people could be reversed.³⁹ She compared her work with the established specialty of paediatrics, recollecting that ‘in my student days children were too often nursed in adult wards ... and too often junior medical and nursing staff were considered all that was necessary for their care’.⁴⁰ Older people could benefit from a dedicated, parallel specialty.

The needs of older people became more apparent at the outbreak of war. In 1939, 140,000 chronically sick people were removed from urban hospitals to provide facilities for anticipated casualties of war.⁴¹ The proximity to Germany and the threat of air-raids and ground combat made this necessary, putting the need for creative attention to the health of older people on the public agenda, ahead of similar considerations elsewhere such as in the USA.

The psychiatric background

Research and academic leadership

During the early 1940s, research on the mental disorders of older people remained limited on both sides of the Atlantic. Studying symptoms of older patients in mental hospitals, or their brains post mortem, emphasised neuropsychology and neuropathological changes usually attributed to ageing, rather than the possibilities of treatment.⁴² One must not under-estimate the value of these scientific studies for understanding the nature of mental disorder, but in isolation their findings could not directly improve patients’ wellbeing.

³⁷ Marjory Warren, ‘The evolution of a geriatric unit from a public assistance institution, 1935-47’ *Proceedings of the Royal Society of Medicine (PRSM)* (1948) 41: 337-338

³⁸ W Dadd, *Administration of Workman’s Compensation*, cited in E Breiger *After-care and Rehabilitation* (Cambridge: Pendragon Press, 1937) 52

³⁹ Warren, ‘Chronic sick’

⁴⁰ *Ibid.* 822

⁴¹ Thane, *Old Age*, 438-439

⁴² G Lawton, ‘Old age and ageing: the present state of scientific knowledge’ *American Journal of Orthopsychiatry* (1940) 10: 27-87; Morris Brody ‘A psychometric study of dementia’ *JMS* (1942) 88: 504-525

Importantly, comments in 1944 by Willy Mayer-Gross (1889-1961), previously professor of psychiatry at Heidelberg then working at Crichton Royal Hospital in Scotland,⁴³ suggested that there was some new thought about how to bridge the gap between pathological findings and the clinical treatment of older people.⁴⁴

Lack of research in the UK on all mental disorders may have reflected the low academic status of psychiatry. Before the war, London, Edinburgh and Leeds⁴⁵ universities had centres for psychiatry, but academic leadership in the UK was otherwise sparse, overshadowed by German universities. In 1946, Aubrey Lewis (1900-76, knighted 1959) was appointed professor in London,⁴⁶ while David Henderson (1884-1965, knighted 1947) was professor in Edinburgh.⁴⁷ Lewis and Henderson were both influenced by German psychiatry and by Adolph Meyer (1866-1950) in the USA.⁴⁸ Lewis trained with Meyer and with leading German psychiatrists.⁴⁹ Henderson trained with Meyer, Emil Kraepelin and Thomas Clouston.⁵⁰ Meyer advocated 'whole person' treatment, social and occupational rehabilitation, multi-disciplinary teams and other practices which became standard in UK psychiatry.⁵¹ Kraepelin (1856-1926), a German psychiatrist, famous for his research methodology and classification of mental disorders, was described by Porter as 'the doyen of early twentieth-century

⁴³ Eliot Slater, 'W. Mayer-Gross' *BMJ* (1961) i: 596-597

⁴⁴ Willy Mayer-Gross, 'Arteriosclerotic, senile and presenile psychoses' *JMS* (1944) 90: 316-327 316

⁴⁵ Leeds Institute of Health Sciences, Academic Unit of Psychiatry and Behavioural Sciences, <http://www.leeds.ac.uk/lihs/psychiatry/> accessed 9.4.2013

⁴⁶ Hugh Series, 'Lewis, Sir Aubrey Julian (1900-1975)', *Oxford Dictionary of National Biography (ODNB)*, OUP, 2004 <http://www.oxforddnb.com/view/article/31359> accessed 3.10.2011

⁴⁷ K Loughlin, 'Henderson, Sir David Kennedy (1884-1965)', *ODNB*, OUP, 2004 <http://www.oxforddnb.com/view/article/47296> accessed 30.12.2011

⁴⁸ Michael Gelder, 'Adolph Meyer and his influence on British psychiatry' 419-435. In: *150 Years of British Psychiatry* ed. German Berrios, Hugh Freeman (London: Gaskell, 1991)

⁴⁹ Michael Shepherd, 'A representative psychiatrist: the career, contributions and legacies of Sir Aubrey Lewis' *Psychological Medicine Monograph* (1986) Supplement 10: 5-31 10

⁵⁰ Loughlin, 'Henderson'

⁵¹ Jack Pressman, *Last Resort: psychosurgery and the limits of medicine* (Cambridge: CUP, 1998) 19, 84

psychiatry'.⁵² Clouston (1840-1915), a psychiatrist in Edinburgh, took a constructive stance towards mentally unwell older people.⁵³

Henderson and Lewis were aware that, with an ageing population, more older people with mental disorders would require medical attention.⁵⁴ Both encouraged modern, active psychiatric clinical approaches and research aimed towards understanding and ameliorating their disorders. Psychogeriatrics began to develop along their academic-clinical lines.

New treatments

A wide range of treatments emerged in the first half of the twentieth century in response to the hypothesis that mental illness was caused by physical changes, like any other illness, and therefore required physical treatment.⁵⁵ Many innovations, subsequently proven to be either unacceptably hazardous or ineffective, were superseded in the 1950s by psychopharmacology, although that too was not without controversy.⁵⁶ One new treatment, electro-convulsive therapy (ECT), was both effective and relatively safe, especially for severe depression. Piloted in Italy in 1938 and introduced into England in 1940,⁵⁷ ECT was soon used to treat older people.

A study of 500 patients by Mayer-Gross evaluating ECT included 76 patients over 60 years with 'depressive states'. His hypothesis was based on a clinical hunch that 'in view of the success of ECT in depressive states of the middle-aged it seemed worth while to take the risk of extending its benefit to patients over 60'.⁵⁸ By stating that he considered it a 'risk', he implied anticipation of adverse effects outweighing benefit. However, side effects were acceptable,

⁵² Porter, 'Dementia' 60

⁵³ Thomas Clouston, *Clinical Lectures on Mental Diseases* (London: J and A Churchill, 1887) 581, 597

⁵⁴ Lewis, 'Ageing and senility'; Post, 'Some problems' 565

⁵⁵ Sargant and Slater, *Physical Methods*, 1-15

⁵⁶ Shorter, *History of Psychiatry*, 249-287

⁵⁷ *Ibid.* 218-221

⁵⁸ Willy Mayer-Gross, 'Electric convulsion treatment in patients over 60' *JMS* (1945) 91: 101-103 101

and results ‘at least equal those in younger age-groups’, especially considering the usual expectations of a ‘much poorer outlook of these psychoses in higher age’.⁵⁹ Unfortunately there was no control group: the value of a randomised controlled study was only just emerging.⁶⁰ Other studies had poorer methodology e.g. using smaller sample sizes,⁶¹ or including relatively few older people, making their results less easy to interpret. One study in the USA included only 17 patients over 65 years out of 1,596 of all ages,⁶² suggesting disparate diagnosis and selection of older compared to younger people. Mayer-Gross’s study appeared particularly meticulous, with clear diagnostic categories and a reasonable sample size on which to base conclusions.

Concluding that some older people with mental disorders could be treated effectively suggested that accurate diagnosis was important: they should no longer be labelled as ‘demented’ without a detailed consideration of their symptoms. However, this view was not readily accepted. Kraepelin’s influential opinions remained sacrosanct; he had labelled almost all psychiatric conditions in old age as irreversible senile dementia.⁶³ Louis Minski, a psychiatrist in London in the 1940s, expressed accepted doctrine, that, in old age, depressive symptoms were part of ‘senile psychosis’, a ‘result of the natural wear and tear of the body’, emphasising its inevitability and hopelessness.⁶⁴ Mayer-Gross’s findings challenged these doctrines.

⁵⁹ *Ibid.* 103

⁶⁰ Benjamin Toth, ‘Clinical trials in British medicine 1858-1948 – with special reference to the development of the randomised controlled trial’ (PhD Thesis, University of Bristol, 1998) 9-10

⁶¹ F Kino, F Thorpe, ‘Electrical convulsion therapy in 500 selected psychotics’ *JMS* (1946) 92:138-145

⁶² Matthew Moore, ‘Electrocerebral shock therapy: a reconsideration of former contraindications’ *Archives of Neurology and Psychiatry* (1947) 57: 693-711 697

⁶³ Emil Kraepelin, *Clinical Psychiatry: a text book for students and physicians*. Abstracted and adapted from the seventh German edition of Kraepelin’s *Lehrbuch der Psychiatrie* by A Ross Diefendorf, revised (London: Macmillan Company, 1918) 369, 378-379, 348; Willy Mayer-Gross, Eliot Slater, Martin Roth, *Clinical Psychiatry* (London: Cassell and Co Ltd, 1960) 505

⁶⁴ Louis Minski, *A Practical Handbook of Psychiatry for Students and Nurses* (London: Heinemann Medical Books, 1946) 62-63

Ideas from Scotland

In the 1940s, psychiatrists in Scotland, including some refugees from Germany and Austria, were central to the development of psychiatry for older people throughout the UK. Refugee doctors were particularly attracted to Scotland where the essential re-qualifying examinations, permitting them to work anywhere in the UK, were more clinically orientated and therefore preferable to those in England.⁶⁵ Rosen remarked that it was not unusual for immigrants to stimulate the development of a new specialty, bringing ideas from abroad, or needing to create a niche for themselves within a medical hierarchy which might otherwise reject them.⁶⁶ For psychiatry, including psychogeriatrics, the contribution of refugee doctors from Nazi Europe is conspicuous.

Erwin Stengel (1902-76), from Vienna, had trained in neuropsychiatry, the diagnosis and management of organic brain diseases, a specialty unknown in Britain⁶⁷ but directly relevant to older people. Stengel contributed to the debate on the nature of mental disorders in old age. He challenged Kraepelin's assertion that senile dementia and Alzheimer's disease, which was originally described in a younger patient, were different conditions. In Stengel's view, they were 'difficult or even impossible' to distinguish.⁶⁸ Unusually for neuropathological descriptions at the time, he endeavoured to relate pathological features to mental state, behaviour and social manifestations. Henderson encouraged him to write up his research.⁶⁹

Felix Post (1913-2001) came from Berlin in 1933 and trained in medicine at St Bartholomew's Hospital, London.⁷⁰ In 1942, Lewis, with whom he had been

⁶⁵ Claire Hilton, 'A Jewish contribution to psychiatry: Edward Mapother, Aubrey Lewis and their Jewish and refugee colleagues at the Maudsley Hospital and Institute of Psychiatry 1933-1966' *Jewish Historical Studies* (2007) 41: 209-229 213

⁶⁶ Rosen, *Specialisation*, 36, 40

⁶⁷ Felix Post, interviewer Margot Jefferys (BLSA, 1991)

⁶⁸ Erwin Stengel, 'A study on the symptomatology and differential diagnosis of Alzheimer's disease and Pick's disease' *JMS* (1943) 89: 1-20 15

⁶⁹ *Ibid.* 20

⁷⁰ Felix Post, letters (FP)

working as a junior doctor, sent him to Henderson for further training. Post later recounted:

One day, Henderson on his rounds, looked around and, 'Post', he said, 'Post, you see all these old people here, why don't you write them up'. So write up I did.⁷¹

Post, in 1944, wrote solely about psychiatric disorders in people aged over 60. That contrasted with the usual situation of older people being accorded little attention by the medical profession in their writing and in clinical practice, and generally being consigned to 'back wards' in mental hospitals. Post emphasised both the growing proportion of older people in the population and the increasing number admitted to hospital. Although not all his observations and diagnoses were accurate by later standards, he took a constructive stance on treatment, including occupational therapy for rehabilitation and social clubs and sheltered housing for 'the social prophylaxis of senile mental illnesses'.⁷² Exploring social influences on the mental wellbeing of older people in an eclectic, multi-disciplinary way was exceptional. Post took a broad approach following Meyer's methods, probably propagated in Edinburgh by Henderson. Post concluded, optimistically, that mental disorders in old age were not an inevitable part of ageing, that depression could be distinguished from dementia and that interventions could be beneficial.⁷³

Post's literature review referred almost entirely to psychiatric sources. He did not mention Warren's recently published work on rehabilitating older physically ill people,⁷⁴ nor did she mention Post in her next report.⁷⁵ This suggests that either they were unaware of each other's reports or had not considered the overlap between their fields. Warren and Post both gave new, positive messages about rehabilitating older people. However, Post's findings were published in a psychiatric journal for a specialist readership and Warren's

⁷¹ Felix Post, interviewer Conrad Woods, Imperial War Museum, Tape 16642 (1996)

⁷² Post, 'Some problems' 561

⁷³ *Ibid.* 588, 564-565

⁷⁴ Warren, 'Chronic sick'

⁷⁵ Marjory Warren, 'Care of the chronic aged sick' *Lancet* (1946) ii: 841-843

were in the widely read *BMJ*. Around the end of the war, Edwin Sturdee, Principal Medical Officer (PMO) at the Ministry of Health, impressed by Warren's 25% discharge rate, sent his assistant, Dr Arthur Leslie Banks, to visit her hospital.⁷⁶ In contrast, Post's sample was drawn from a private mental hospital in Scotland, outside the authority of the Ministry of Health. His findings were quantitatively less robust, he did not dramatically reduce bed occupancy and his suggestions for clinical management were more tentative. All these factors may have contributed to Warren's paper having a more global impact than Post's. Martin commented that 'it is debatable whether geriatrics would have developed' as far as it did in the 1950s if it was not for the increased bed turnover which it provided.⁷⁷ Reducing bed numbers was an important factor for the Ministry. Post's study did not demonstrate that for mental hospitals, and the Ministry did not appear to raise the possibility.

Suggestions from psychiatrists working in Scotland about mental illness in old age complemented those beginning to appear from Lewis in London. Similar ideas from psychiatrists elsewhere in the UK have not been detected.

Aubrey Lewis and his legacy

Lewis's concerns

In 1943, Lewis and his social work colleague, Helen Goldschmidt, reported on the social reasons for admission to Tooting Bec Hospital, South London. This unique mental hospital was founded in 1903 to accommodate older people. Its urban location was chosen to facilitate visiting by family and friends. A special Act of Parliament permitted admission of people over the age of 70 without Lunacy Act certification.⁷⁸ Lewis and Goldschmidt concluded that, rather than severity of illness, social factors often precipitated admission. These included poverty, poor diet, enforced change of living accommodation due to bombing,

⁷⁶ Trevor Howell, 'Aspects of the history of geriatric medicine' *PRSM* (1976) 69: 445-449 445-446; Trevor Howell, 'The origins of the British Geriatrics Society' *Age Ageing* (1974) 3: 69-72 69; A Leslie Banks, 'Care of the infirm and the long-stay patient' *Monthly Bulletin of the MoH* (1944) 4: 112-118

⁷⁷ Martin, 'Medical knowledge' 452

⁷⁸ MoH, *Survey of Services Available to the Chronic Sick and Elderly 1954-55* (Boucher Report) (London: HMSO, 1957) 47

and socially unacceptable behaviours such as disinhibition or wandering the streets at night. They observed that many ‘could (and do) improve and return to the community when social circumstances are favourable’.⁷⁹ They recommended multi-disciplinary ‘non-residential advisory centres for the ageing and aged’, modelled on child guidance clinics⁸⁰ which were much acclaimed for their holistic approach and were increasing in number.⁸¹ Lewis and Goldschmidt’s recommendation, to support people at home rather than admit them to scarce beds, was also in line with the war effort. Their paper was published in the *Sociological Review*. This major sociological journal, however, contained little of direct relevance to medical or social work practice or to developing health service policies. It was unlikely to be read widely by government officials responsible for health and welfare services.

In another paper, ‘Ageing and senility’, Lewis emphasised the effects of projected demographic changes on mental hospital populations, commenting that older people would comprise the majority of admissions ‘within the next thirty years’.⁸² Mental hospital admission figures, Lewis stated, underestimated the number of people with senile dementia as many were housed in public assistance institutions. However, little clinical information was available from those institutions, which were not subject to the legally enforced rigorous record keeping required of mental hospitals. Lewis used evidence from the USA to support his estimates, quoting their even steeper rise in mental hospital admissions of older people in the absence of a British style public assistance system.⁸³ Lewis’s conclusion on bed occupancy was supported by the results of a study of chronic sick hospitals in Leeds by a municipal hospital deputy medical superintendent, James Affleck. Affleck, unusually, had a psychiatric qualification,⁸⁴ and thus probably better understanding and clinical

⁷⁹ Lewis and Goldschmidt, ‘Social causes’ 96

⁸⁰ *Ibid.* 97

⁸¹ John Stewart, ‘The scientific claims of British child guidance, 1918-1945’ *British Journal for the History of Science* (2009) 42: 407-432

⁸² Lewis, ‘Ageing and senility’ 169

⁸³ *Ibid.* 167-168

⁸⁴ James Affleck, ‘Psychiatric disorders among the chronic sick in hospital’ *JMS* (1948) 94: 33-45 33, 37

and diagnostic skills relating to psychiatric disorders, than superintendents elsewhere. Thirty-five *per cent* of Affleck's patients over 65 had a 'psychiatric disease or complication',⁸⁵ remarkably high, considering that 'psychiatric cases were not admitted as such'.⁸⁶

Data from long-stay institutions were important, but could not adequately estimate prevalence of mental disorders or needs in the community. Joseph Sheldon's study⁸⁷ began to address those points. Otherwise, institutional clinical data risked underestimating the services required for psychogeriatric treatment and care, which potentially undermined even the most generous government plans.

Lewis justified his failure to analyse his mental hospital data by diagnostic group as, in his view, terminology was 'in a mess'.⁸⁸ He commented about old age mental health that 'it is doubtful whether there is a wide enough recognition of how fascinating the problems are, and how pressing the theme'.⁸⁹ He was unique in combining an interest in older, mentally unwell people with a position of influence within English psychiatry, but his interest in older people was secondary to his psychiatric education priorities.

Lewis and the Geriatric Unit

Lewis's main objective was to establish a teaching hospital to improve the education of psychiatrists. He advocated a broad curriculum, including old age mental disorders, since 'the psychiatry of the old will ... become a prominent part of our branch of medicine' and he believed that a well trained psychiatrist should be able to treat patients of any age, including children.⁹⁰ Specialist education within psychiatry, rather than creating new psychiatric specialties, was important to him, even though some separate specialties (forensic, child

⁸⁵ *Ibid.* 37

⁸⁶ *Ibid.* 35

⁸⁷ Sheldon, *Social Medicine*, discussed below, pages 88-90

⁸⁸ Lewis, 'Ageing and senility' 169

⁸⁹ *Ibid.* 170

⁹⁰ Aubrey Lewis, 'The education of psychiatrists' *Lancet* (1947) ii: 79-83 83

and ‘mental deficiency’) already existed.⁹¹ His concerns reflected the Ministry of Health’s report on medical education in 1944, which noted insufficient teaching about psychiatry by inadequately trained staff and recommended improved post-graduate training.⁹²

Lewis worked at the Maudsley Hospital in South London, named after its benefactor Henry Maudsley (1835-1918).⁹³ It opened in 1923 as the first post-graduate teaching hospital for psychiatry in England. It was strongly influenced by German university psychiatry and by Maudsley’s ideals for research, teaching and treatment of people with acute mental illnesses which were regarded as likely to improve.⁹⁴ Although it admitted people of all ages, in some years between 1924 and 1938, no in-patient was over 70,⁹⁵ reflecting the ethos of other teaching hospitals of prioritising acute treatment for younger people.

In 1948 the Maudsley merged administratively with the Bethlem Royal Hospital several miles away, becoming the Bethlem-Maudsley Hospital. Lewis, as professor, automatically sat on the main administrative decision making body of the joint hospital, the General Purposes Sub-committee of the Medical Committee. He was a dominant figure, and people shied away from opposing him.⁹⁶ In this position he could shape developments according to his objectives.

Previously at the Bethlem Royal, in-patients over age 60 were scattered among younger patients.⁹⁷ Placing frail elderly people in a ward with younger and

⁹¹ BMA Psychological Medicine Group, Group of Practitioners of Psychological Medicine, ‘The future of psychiatry’ (1943) 4-8, 10 (British Medical Association Archives, BMAA)

⁹² MoH and DoH for Scotland, *Report of the Inter-Departmental Committee on Medical Schools* (Goodenough Report) (London: HMSO, 1944) 181-187

⁹³ Trevor Turner, ‘Maudsley, Henry (1835-1918)’, *ODNB*, OUP, 2004
<http://www.oxforddnb.com/view/article/37747> accessed 19.3.2010

⁹⁴ Patricia Allderidge, ‘The foundation of the Maudsley Hospital’ 79-88. In: *150 Years* ed. Berrios and Freeman, 83

⁹⁵ Edgar Jones, Shahina Rahman, ‘Framing mental illness, 1923-1939: the Maudsley Hospital and its patients’ *SHM* (2008) 21: 107-125 118

⁹⁶ Michael Gelder, ‘Sir Aubrey Lewis’s contributions to psychiatry’ *BJPsych* (1976) 128: 31-35

⁹⁷ Jones and Rahman, ‘Framing mental illness’

fitter disturbed patients was unsafe. It also impeded the development of specific expertise for their assessment and treatment; grouping similar patients together was known to promote more rigorous observation and enhance knowledge in a field.⁹⁸ Thus, in keeping with his educational objectives, Lewis planned a 'Geriatric Unit'. The term 'Geriatric Unit' is potentially ambiguous, but it was 'geriatric' in the context of being an old age unit within a psychiatric hospital rather than being linked to the specialty of geriatric medicine.

At the Bethlem-Maudsley, the ethos of active treatment for younger people was deeply embedded. A hospital report for 1949 to 1951 stated that 'the activities of the hospital are mainly directed to people of a productive and socially important age group'.⁹⁹ This hinted at the eugenics movement of which one of its authors, psychiatrist Carlos Blacker, was a member.¹⁰⁰ It risked adding to existing negative attitudes towards work with older people. The hospital's ethos also meant that Lewis could justify the Geriatric Unit solely for people with potentially treatable functional mental illnesses, which he believed could be diagnosed in that age group, rather than for dementia.¹⁰¹ However, since mainstream understanding was that untreatable dementia was the overarching condition in old age, Lewis's colleagues regarded the Geriatric Unit as 'an almost revolutionary proposal'.¹⁰²

Post's 1944 paper about older people came to Lewis's attention.¹⁰³ It had implications for Lewis's plans. Lewis encouraged Post to apply for a vacancy at the Maudsley in 1947.¹⁰⁴ Aware of his status as a refugee, Post knew that

⁹⁸ George Weisz, 'The emergence of medical specialization in the nineteenth century' *Bulletin of the History of Medicine* (2003) 77: 536-575 546, 575

⁹⁹ Carlos Blacker, A Gore (ed.) *Statistical Triennial Report 1949-1951* (London: Bethlem Royal Hospital and Maudsley Hospital, 1955) 16

¹⁰⁰ Richard Soloway, 'Blacker, Carlos Paton (1895-1975)', *ODNB*, OUP, 2004 <http://www.oxforddnb.com/view/article/47726> accessed 4.6.2012

¹⁰¹ Lewis, 'Ageing and senility' 169

¹⁰² Felix Post, 'Geriatric Unit' *Bethlem Maudsley Hospital Gazette (BMHG)* (1955) 1: 270-271 270

¹⁰³ Lewis, 'Ageing and senility' 170; Post, 'Some problems'

¹⁰⁴ Claire Hilton, 'Felix Post (1913-2001) pioneer in the psychiatry of old age' *Journal of Medical Biography* (2007) 15: 31-36 31, 32

anti-German feelings could prevent him from obtaining employment, especially in a teaching hospital.¹⁰⁵ Those prestigious posts were usually filled by UK born graduates who had served in the Forces during the war.¹⁰⁶ Thus, after securing a Maudsley teaching hospital job, he felt indebted to Lewis, and very much under his influence. Unknown to Post, Lewis had earmarked him to run the Geriatric Unit.¹⁰⁷ Post was ambivalent: 'I obeyed (to say without enthusiasm would be an understatement)'.¹⁰⁸ His ambivalence echoed that of contemporaries, including the hospital's Matron. She had a 'stand-up row' with Lewis about his plan and is reported to have commented: 'lovely wards with nasty old people'.¹⁰⁹ Post's ambivalence was linked to his perception that 'it was a pretty hopeless task where not many therapeutic laurels were likely to be won, in terms of satisfaction with one's work'.¹¹⁰ In 1949, Post became the first psychiatrist to head the new psychiatric Geriatric Unit with a focus on active treatment, unique in the UK and probably in the world.¹¹¹

Although Post took a lead in treating older people within the hospital, in the early years he was not involved on external committees. Lewis probably regarded prestigious national external appointments, such as the Mental Health Standing Advisory Committee (MH-SAC), one of several SACs set up to advise the Central Health Services Council of the NHS on various aspects of health care, as requiring his expertise. Both inside and outside the Maudsley, Post was subordinate to Lewis. Post regarded Lewis as the 'father' of the project, whilst he was the 'reluctant son' and 'just a cog in the wheel as a dispenser of wisdom which I had not yet collected'.¹¹²

¹⁰⁵ Felix Post, interviewer unknown (c.1996) (FP)

¹⁰⁶ Cooper, *Pride versus Prejudice*, 232-233, 253

¹⁰⁷ Felix Post, interviewer Brian Barraclough (1988) Edited transcript, 157-177. In: *Talking about Psychiatry* ed. Greg Wilkinson (London: Gaskell, 1993) 165

¹⁰⁸ Felix Post, 'In the beginning' 15-16. In: *Principles and Practice* ed. Copeland *et al.* 15

¹⁰⁹ Post (BLSA)

¹¹⁰ *Ibid.*

¹¹¹ Felix Post to Bethlem-Maudsley Medical Committee, letter, 13.10.1949, GPD31/49 MCD73/49 (BMHA)

¹¹² Post (BLSA)

‘Ageing and Senility’

In 1945, the annual conference of the Royal Medico-Psychological Association (RMPA, the authoritative body of UK psychiatrists; predecessor of the Royal College of Psychiatrists) included a seminar, ‘Ageing and Senility’.¹¹³ It comprised presentations by Lewis, Goldschmidt, psychologist Margaret Eysenck and neurochemist Derek Richter, all working at the Maudsley.¹¹⁴ Papers delivered by the first three were published in the *JMS*. Richter’s, ‘Some biological changes in senility’,¹¹⁵ has not been traced. Lewis’s paper ‘Ageing and senility’ has already been discussed.

Goldschmidt’s study included 200 people, some in-patients at Tooting Bec, and others dwelling in various London communities. It aimed ‘to discover what social factors might be said to contribute to ... mental health in old age’.¹¹⁶ Community social support would be crucial, she stated, to prevent admission and enable people to be discharged from hospital, and research would be essential to identify how rehabilitation might best be achieved.¹¹⁷ This was in line with new thinking in geriatric medicine.

Eysenck reviewed the literature and described her own research on psychological aspects of ageing. The lack of information on intellectual function and ageing in the normal population was significant; she proposed longitudinal studies to explore intellectual, emotional, attitudinal, temperamental and physiological changes over the lifespan. Her conclusions illustrated existing negative attitudes toward older people. For example, she highlighted emerging evidence indicating the ‘surprising and interesting fact, showing that the older person retains a *desire* to learn’.¹¹⁸ This contrasted with

¹¹³ 104th Annual Meeting of the RMPA, September 1945, *JMS* (1946) 92: Supplement: 14

¹¹⁴ Helen Goldschmidt, ‘Social aspects of ageing and senility’ *JMS* (1946) 92: 182-194; Margaret Eysenck, ‘The psychological aspects of ageing and senility’ *JMS* (1946) 92: 171-181; Gerald Gaull, ‘Derek Richter, PhD MD 1907-1995’ *Neurochemical Research* (1996) 21: 1267-1268 1267

¹¹⁵ 104th Annual Meeting

¹¹⁶ Goldschmidt, ‘Social aspects’ 182

¹¹⁷ *Ibid.* 190

¹¹⁸ Eysenck, ‘Psychological aspects’ 173, 179

the better known dogma of Sigmund Freud (1856-1938) who had negative views of older people. Freud, when he was about 48 years old, had the audacity and surprising lack of self-reflection to state: 'Near or above the age of 50 the elasticity of mental process, on which the treatment depends, is, as a rule lacking – old people are no longer educable'.¹¹⁹ Freud's eminence was such, that, similar to his contemporary Kraepelin, his statements had long-lasting consequences; they continue to affect psychological practice in the twenty-first century.¹²⁰ New knowledge which challenged respected ideas and pre-existing cultural expectations would not easily make an impact.

Alfred Petrie, president of the RMPA, chaired the seminar. Petrie had recently written on 'Mental health services – present and future' which overlooked older people.¹²¹ Discussion at the seminar raised strong, often negative attitudes from other psychiatrists. For example, Arthur Pool, a mental hospital medical superintendent contributed to the discussion:

he would like to learn from some medical officer of Tooting Bec what it was like to be a medical officer in an institution which dealt solely with senile cases. His impression was that it was not very attractive. After all, they had to consider the medical personnel as well as the patients.¹²²

No answer was recorded. Douglas McCalman pointed out that there were already out-patient departments which 'must be beginning to play a part in this question of senility'.¹²³ The British Medical Association (BMA) report on mental health in 1941 identified 125 psychiatric out-patient clinics in England, Scotland and Wales, but 'not all the clinics ... give adequate service'.¹²⁴ Neither McCalman nor the BMA mentioned any clinics specifically for older

¹¹⁹ Sigmund Freud, 'On psychotherapy' (1905 [1904]) 257-268. In: *The Standard Edition of the Complete Psychological Works of Sigmund Freud* tr. ed. James Strachey, Vol. vii (London: Hogarth Press, 1953) 264

¹²⁰ Marie-Clare Mendham, 'To age or not to age, that is the conundrum' *OAP* (2011) 53: 29-30 29

¹²¹ Alfred Petrie, 'Mental health services - present and future' *JMS* (1944) 90: 3-19

¹²² Arthur Pool, In: 'General discussion' *JMS* (1946) 92: 191-194 193

¹²³ Douglas McCalman, In: 'General discussion' 193

¹²⁴ BMA Committee on Mental Health, *Report* (London: BMA, 1941) 16

people. Indeed, the BMA reports failed to mention dementia or older people, despite their increasing presence within the mental hospitals.

Iverson Russell, medical superintendent of North Riding Mental Hospital, York, remarked:

it seemed unlikely that they would be able to prevent themselves from growing old ... the question they really ought to ask, when considering the most suitable way of treating old people, ... was ... what sort of institution they themselves would want to go into. His own choice would be for a small place, not a large one.¹²⁵

For Russell, the dependency of old age was part of unavoidable ageing rather than illness, implying, like the BMA reports on mental health,¹²⁶ that it was not the responsibility of psychiatrists, who, as doctors, treated illness. However, four years later, when Russell was president of the RMPA, unlike his predecessor Petrie, he advocated for older people, recognising the need for small specialist residential units away from the mental hospitals.¹²⁷ Whether the RMPA seminar had triggered his interest is not known, but including needs of older people in discussions of mental wellbeing across the lifespan was unusual. Overall, despite Lewis's enthusiasm, the RMPA discussion revealed significant ambivalence from other psychiatrists towards mentally unwell older people.

Geriatric medicine and psychiatric disorders

In contrast to Lewis's teaching hospital initiative, geriatric medicine was emerging from the municipal hospitals as a pragmatic, clinically effective specialty.

Despite Warren's treatment and rehabilitation goals, she made no suggestion that mental conditions could be ameliorated. Mental health was not her main expertise and she perhaps accepted prevailing psychiatric opinion. Warren's

¹²⁵ Iverson Russell, In: 'General discussion' 194

¹²⁶ BMA Committee on Mental Health; BMA, 'Future of psychiatry'

¹²⁷ Iverson Russell, 'The role of the mental hospital in the National Health Service' *JMS* (1949) 95: 785-794 793

report in 1943 indicated that she cared for ‘senile demented’, even with disturbed behaviours, and she did not suggest that they were the responsibility of psychiatrists.¹²⁸ If geriatricians regarded older, mentally unwell people as their patients, this would not encourage psychiatric involvement despite opportunities for collaboration recognised during the 1940s.¹²⁹

Despite the potential to rehabilitate older people, and acknowledgement in the *JMS* of the coexistence of physical and mental disorders,¹³⁰ evidence is lacking that psychiatrists followed Warren’s example of systematically investigating their own older in-patients to detect potentially treatable physical conditions. Many mental hospitals had their own infirmary wards. Younger psychiatric in-patients who developed physical illness might be transferred to them or to general hospitals. However, without proactively assessing older in-patients, given the less obvious presentation and chronic nature of physical disorders in old age, they were unlikely to receive active treatment.

The coexistence of physical and psychiatric disorders was highlighted in Dr Charles Andrews’ survey of institutional chronic sick care in Cornwall in 1947, which the County Medical Officer of Health had asked him to undertake.¹³¹ He noted ‘borderline or certifiable mental patients ... in the same ward’ as medical patients, and commented on the difficulties of nursing in a ‘unit of sixty chronic sick patients many of whom are suffering from senile dementia’.¹³² He found unacceptable facilities, such as earth closets and one bath for 50 residents.¹³³ Nursing standards were high despite low staffing levels, but there was no rehabilitation. Procedures for looking after mentally unwell people increased their dependency:

¹²⁸ Warren, ‘Chronic sick’ 822

¹²⁹ BMA, *Care and Treatment*, 10-11

¹³⁰ Affleck, ‘Psychiatric disorders’

¹³¹ Andrews, ‘Early days’ 117

¹³² Truro Public Assistance Committee, Institutions and general purposes sub-committee, minutes, 15.9.1947, 14 (BGSA)

¹³³ Andrews, ‘Early days’ 118

The senile patient is much easier to manage in bed ... Getting around he may fall down stairs ... The result is that patients who have been getting around at home gradually become confined to bed.¹³⁴ (Fig 3)

Fig 3. Nursed in a workhouse in Cornwall, 1947



Source: Dr Gordon Langley, Exeter.

Andrews' findings were not unique; poor facilities were evident in recently undertaken hospital surveys¹³⁵ and in a report by a nurse describing her experience of caring for older people in the 1940s:

wards which looked like railway stations ... beds so close together that one had to move them to get close to any patient who needed attention ... [I]t was not uncommon to have three or four deaths in any one night ... it was difficult to identify patients who had died because neither patients nor beds were labelled.¹³⁶

Andrews' report quickly led to the establishment of a proactive, treatment-focussed service in Cornwall.¹³⁷ Its aims included that: all patients admitted to public assistance institutions would have a comprehensive assessment within two weeks; a separate unit would be created for geriatric rehabilitation; disturbed demented people would be separated from the other patients; and

¹³⁴ Truro Public Assistance Committee, 17 (BGSA)

¹³⁵ Gray and Topping, *Hospital Survey*, 6

¹³⁶ Annie Altschul, Department of Nursing Studies open day, lecture, 3.7.1983 (RCNA, C305/1/2)

¹³⁷ Charles Andrews, Thomas Wilson, 'The organisation of a geriatric service in a rural area' *Lancet* (1953) i: 785-789 786-787

older people would be admitted to voluntary hospitals for active treatment if necessary.¹³⁸

A review of Andrews' new service in 1953 commented that behavioural problems of patients produced an 'intolerable strain' on the geriatric ward. In particular, 19% were 'confused and irrational' at the time of admission. A psychiatrist was among the visiting specialists assessing patients. Unfortunately, there was no indication of a reciprocal relationship, with geriatricians visiting the West Cornwall Mental Hospital, where 44% of beds were occupied by older people.¹³⁹ As Andrews acknowledged, the 'interest and enthusiasm of a few local people' triggered the survey and the subsequent developments,¹⁴⁰ but its message did not spread rapidly to other places. Suggestions from central government were unlikely to materialise without local motivation and enthusiasm.

Lionel Cosin was another geriatric pioneer. In 1940,¹⁴¹ in order to vacate beds at Orsett Lodge Hospital, Essex, to accommodate predicted war time casualties, he began to use rehabilitation techniques with older people.¹⁴² Cosin qualified in medicine in 1933, then trained as a surgeon, but did not settle into any particular specialty. His experience of unanticipated clinical success with older people ignited his interest in them and geriatric medicine remained his niche. Serendipitous rewarding experiences when treating older patients could create unexpected enthusiasm for the specialty, as could working with an inspiring senior colleague: Warren's relationship with her junior doctors was described as that of guru and disciple.¹⁴³ Positive experiences were important for recruitment into the field.

¹³⁸ Truro Public Assistance Committee, 39 (BGSA)

¹³⁹ Andrews and Wilson, 'Rural area' 787, 788

¹⁴⁰ Andrews, 'Early days' 122

¹⁴¹ RE Irvine, 'LZ Cosin' *BMJ* (1994) 309: 189

¹⁴² Lionel Cosin, interviewer Margot Jefferys (BLSA, 1991)

¹⁴³ Margot Jefferys, 'Recollections of the pioneers of the geriatric medicine specialty' 75-96. In: *Oral History, Health and Welfare* ed. Joanna Bornat, Robert Perks, Paul Thompson, Jan Walmsley (London: Routledge, 2000) 88

In 1949, Lord Amulree (1900-83), a hereditary peer who qualified in medicine in 1935, established the first teaching hospital geriatric department in the UK. This aimed to provide medical students with knowledge, skills and constructive attitudes necessary for working with older people. The department was at University College Hospital, London,¹⁴⁴ albeit not located in the main building but in the nearby St. Pancras wing, a former workhouse (Fig 4).

Fig 4. St. Pancras Hospital, 2010



Source: Photographed by author

Amulree was a prolific writer and advocate for geriatric services. His outspoken statements on the welfare of older people appeared in the national press.¹⁴⁵ As co-author of a Liberal Party pamphlet on old age in 1949, he recommended that ‘senile dementers’

should be admitted to special wards where they can receive skilled treatment; for contrary to common belief, treatment can lead, in early cases, to lasting improvement.¹⁴⁶

Any clinical optimism was rare: he might have been referring to delirium or depression, otherwise, the precise reason for his optimism is unclear. Amulree and Sturdee worked together at the Ministry of Health. In 1946 they addressed

¹⁴⁴ Michael Denham, ‘Lord Amulree: an appreciation’ *Age Ageing* (2005) 34: 529-531

¹⁴⁵ Lord Amulree, scrapbooks (BGSA)

¹⁴⁶ Arthur Seldon, Lord Amulree, Barbara Lewis, *The Aged and the Nation* (London: Liberal Publications Department, 1948) 59

the Parliamentary Medical Group on the needs of older people, emphasising rehabilitation but not mentioning psychiatric disorders.¹⁴⁷ Amulree prioritised physical health and did not directly take up the psychogeriatric cause.

Amulree and Lewis both advocated for older people but it is unclear whether they were aware of each other's work. Both were forceful characters with their own agendas which formally remained on separate tracks. When Lewis advocated for older people on the MH-SAC, psychiatric and geriatric planning were not coordinated; the MH-SAC made decisions on psychiatry for older people, and a medical SAC planned geriatric services.¹⁴⁸

Doctors, however few, were the main professional group arguing for better and dedicated provision for older people's health needs. The Medical Society for the Care of the Elderly (MSCE, later British Geriatrics Society, BGS), founded in 1947, started as an informal meeting of a few geriatricians but rapidly emerged as a forceful group aiming to improve standards of medical care for older people.¹⁴⁹

New ideas emerged about older people simultaneously in medicine and psychiatry.¹⁵⁰ Both specialties opened units in teaching hospitals in 1949. Geriatric medicine was recognised as a specialty by the NHS in 1948¹⁵¹ and psychogeriatrics 41 years later.¹⁵² Recognition of geriatric medicine was associated with the appointment of six consultant geriatricians in the new NHS¹⁵³ and gave scope for further recruitment. Recruitment was probably assisted by refugee doctors and others recently demobbed and eager for

¹⁴⁷ Lord Amulree, Edwin Sturdee, 'Care of the chronic sick and of the aged' *BMJ* (1946) i: 617-618 617

¹⁴⁸ MH-SAC, 'Subjects for discussion' in Medical SAC meeting, 29.3.1949 (TNA, MH 133/502)

¹⁴⁹ Barton and Mulley, 'History and development' 231

¹⁵⁰ Warren, 'Chronic sick'; Post, 'Some problems'

¹⁵¹ J Grimley Evans, 'Geriatric medicine: a brief history' *BMJ* (1997) 315: 1075-1077 1076

¹⁵² Arie and Jolley, 'Psychogeriatrics' 262

¹⁵³ Norman Exton-Smith, Peter Millard, 'Hospital services for the elderly' *Care of the Elderly* DHSS Conference proceedings, 1973, cited in Denham, 'Geriatric medicine' 201, 357

employment, thus allowing the specialty to expand and develop. This was not paralleled in psychogeriatrics.

Central government and the creation of psychogeriatric services

Sir William Beveridge's report *Social Insurance and Allied Services* in 1942 was the blueprint for a national insurance scheme. It aimed to tackle the 'five giants on the road of reconstruction': disease, ignorance, squalor, idleness and want.¹⁵⁴ Webster commented that it was the 'first modern social planning document to recognise the importance of the problems of the elderly'.¹⁵⁵

Some non-governmental initiatives aimed to improve welfare in old age. For example, the Old People's Welfare Committee founded in 1940 became 'National' in 1944 (NOPWC; then Age Concern, and since 2009, Age UK), taking under its umbrella many local organisations with similar objectives.¹⁵⁶ The National Federation of Old Age Pensions Associations originated in 1938,¹⁵⁷ and the National Corporation for the Care of Old People in 1947 (NCCOP; later, Centre for Policy on Ageing, CPA).¹⁵⁸ Thane commented that older people were becoming 'assertive proponents of their own interests',¹⁵⁹ although that seemed to be more prominent in the pensions domain than for health. Some potentially all-age organisations, such as the National Association for Mental Health (NAMH; MIND 1972-1990s, then Mind) tended to prioritise younger people. NAMH was founded in 1946 by amalgamating three organisations, the Child Guidance Council, a charity focussing on mental deficiency, and one with a strongly educational bias which stressed the social causes of mental illness.¹⁶⁰ Older people were outside their sphere of activity.

¹⁵⁴ Beveridge, *Social Insurance*, 6

¹⁵⁵ Webster, 'The elderly' 165

¹⁵⁶ Age UK, <http://www.ageuk.org.uk/about-us/who-we-are/our-history/> accessed 28.7.2010

¹⁵⁷ Pensioners' Voice, <http://www.pensionersvoice.co.uk/content/information/the-story-of-the-pensioners-voice> accessed 11.11.2011

¹⁵⁸ Centre for Policy on Ageing, http://www.cpa.org.uk/cpa/about_cpa.html accessed 23.10.2011

¹⁵⁹ Thane, *Old Age*, 331

¹⁶⁰ Mind, 'A history of Mind' http://www.mind.org.uk/about/what_we_do/a_history_of_mind accessed 30.4.2013

Concerning health, Beveridge stated, as an ideal, 'for every citizen there is available whatever medical treatment he [sic] requires, in whatever form he requires it'.¹⁶¹ What 'he requires' meant was open to interpretation by society including politicians and the medical profession. Birth rates had been falling, infant mortality had increased at the beginning of the war¹⁶² and it was projected that one in six of the population would be of pensionable age by 1961.¹⁶³ Welfare planners were not to know that this was a significant overestimate. In this context, Beveridge advised:

the provision made for old age must be satisfactory; otherwise great numbers may suffer ... It is dangerous to be in any way lavish to old age, until adequate provision has been assured for all other vital needs, such as the prevention of disease and the adequate nutrition of the young.¹⁶⁴

This unambiguously relegated older people to lower priority. Nevertheless, NHS treatment, generally available according to need rather than ability to pay, was an asset for older people who were often financially disadvantaged. The new system contrasted, for example, with private insurance health care in the USA which was of greater benefit to the better off. There, the means tested Medicaid and Medicare social welfare schemes which included older people did not begin until 1965. The USA schemes also, inequitably, provided lower reimbursement rates for mental (50%) compared to physical (80%) disorders.¹⁶⁵

Beveridge recognised that old age was a cause of inability to earn and therefore also of poverty. Old age poverty was severe, although not as profound as in the pre-war decades, partly owing to the introduction of supplementary pensions for those in 'straightened circumstances' under the Old Age and Widows' Pension Act 1940.¹⁶⁶ The subsistence level pensions suggested by Beveridge

¹⁶¹ Beveridge, *Social Insurance*, 158

¹⁶² Joe Hicks, Grahame Allen, *A Century of Change: trends in UK statistics since 1900* (House of Commons Library, Research Paper 99/111, 1999) 8-9

¹⁶³ Beveridge, *Social Insurance*, 90-91

¹⁶⁴ *Ibid.* 92

¹⁶⁵ Rabins, 'Psychogeriatrics in the US' 372

¹⁶⁶ Old Age and Widows' Pension Act 1940, 3 and 4 Geo 6, chapter 13; Emily Samson, *Old Age in the New World* (London: Pilot Press, 1944) 15

were intended to provide enough to live on without ‘want’ although nothing more. Everyone, Beveridge remarked, should be given the maximum encouragement to save for old age and other periods of need ‘for maintenance of standards above the subsistence minimum’ which ‘avoids spending [public] money which is urgently needed elsewhere’.¹⁶⁷ Beveridge proposed ways to overcome the fears of older people ‘draining’ society, such as building in a flexible retirement age to enable those who could to work to later ages. However, the post-war government did not implement the proposals concerning subsistence level old age pensions or flexible retirement.¹⁶⁸ Post-war implementation perpetuated old age poverty and demeaning means testing for additional benefits, with associated health disadvantages linked to factors such as poorer housing, nutrition and heating.

Beveridge’s report was intended to be concerned only with social insurance. The inspiration for the NHS came from elsewhere, including from proposals in the 1930s, observations of the success of the EMS, and the 1944 White Paper *A National Health Service* proposed by Henry Willink, the Conservative Minister of Health,¹⁶⁹ although there were significant deviations from that in the longer term.¹⁷⁰ Aneurin Bevan, Minister of Health in the post-war Labour government, was determined to achieve the objective of a universal health service free at the point of delivery. Despite public support for the service, there was opposition, including from local government associations, voluntary hospitals, some doctors and the BMA. As with the Beveridge report, the new scheme challenged vested interests and ideological loyalties.¹⁷¹

¹⁶⁷ Beveridge, *Social Insurance*, 92

¹⁶⁸ Jose Harris, ‘The roots of public pension provision: social insurance and the Beveridge Plan’ 27-38. In: *Britain’s Pensions Crisis* ed. Hugh Pemberton, Pat Thane, Noel Whiteside, (Oxford: OUP, 2006) 34

¹⁶⁹ MoH and DoH for Scotland, *National Health Service*

¹⁷⁰ Webster, *Political History*, 11

¹⁷¹ Charles Webster, ‘Something to celebrate: the BMA and the NHS’ *BMJ* (1998) 317: 45-47 46; Webster, *Political History*, 3, 8

Surveys of physical illness hospitals were carried out to help the Ministry of Health plan the new health service.¹⁷² The survey of London and the surrounding counties exposed the grim state of institutional services for older people, commenting that some institutions were ‘not worthy of the name of hospital’.¹⁷³ Mental hospitals were excluded from this survey, since plans for general and mental hospitals differed. This hid their deficits. The BMA was among those arguing that improved mental health services would only come about with their integration into a comprehensive health service.¹⁷⁴ However, separation was justified by the Board of Control, on the grounds of the vast scale and separate identity of mental institutions and that it would be difficult to achieve full NHS integration before reform of mental health legislation which required a Royal Commission.¹⁷⁵ Those most likely to be affected by not integrating community, general and mental hospital services were people with multiple health and social problems, commonest in old age. Mental hospitals were eventually included in the NHS on the grounds of fulfilling the recommendations of the Royal Commission on Lunacy and Mental Disorders of 1926, that mental illness should be provided for similarly to physical illness.¹⁷⁶

From the data available, it is difficult to be precise about the proportion of NHS beds occupied by mentally unwell people generally, regardless of age. Data are inconsistent and difficult to compare; for example, they may cite both ‘available’ and ‘occupied’ bed numbers within a single report, and it might be unclear whether mental hospital bed allocation included ‘mental deficiency’. In 1950, data referred to 146,278 occupied mental hospital beds compared to

¹⁷² Webster, ‘The elderly’ 167

¹⁷³ Gray and Topping, *Hospital Survey*, 6

¹⁷⁴ Psychological Medicine Group, minutes of conference, 5.5.1943 (BMAA) 5; Charles Webster, *The Health Services since the War*. Vol. 1 *Problems of Health Care: the National Health Service before 1957* (London: HMSO, 1988) 327

¹⁷⁵ Anne Rogers, David Pilgrim, *Mental Health Policy in Britain: a critical introduction* (Basingstoke: Macmillan Press, 1996) 64-65

¹⁷⁶ MoH and DoH for Scotland, *National Health Service*, 9; *Report of the Royal Commission on Lunacy and Mental Disorders* Cmd. 2700 (London: HMSO, 1926) 15-17

397,570 ‘average occupied’ non-psychiatric beds,¹⁷⁷ adding to difficulties of numerical comparisons and interpretation. However, in 1948, official reports indicated that almost 25% of patients in the mental hospitals were over age 65,¹⁷⁸ and rising.¹⁷⁹ Demographic change, with the 65-74 year age band comprising 7.3% of the total population, and the over 75s, in whom degenerative disorders would be most frequent, 3.8%,¹⁸⁰ seemed unlikely to account fully for this trend. Other possible factors included older patients being treated differently from younger patients, including different criteria for admission, less rehabilitation and different expectations of outcome by patients, family and staff.

Overall, mental disorders were not well provided for. Little could be done to improve the mainly Victorian asylum buildings.¹⁸¹ Equipment and furnishings were often of lower standard than in general hospitals, and patients who were sufficiently physically fit provided cheap labour to keep the hospitals running, to the extent that one medical superintendent commented: ‘If the patients called a general strike the hospital could be severely handicapped’.¹⁸² In a letter to the *BMJ* in 1946, Eric Dax and Francis Reitman, psychiatrists at Netherne Mental Hospital, Surrey, commented that provision for older and infirm people was ‘often treated like a stepchild’, implying that it was unequal and unjust. They proposed ‘proper’ treatment and rehabilitation for older people, equitable with that provided for younger patients, plus non-hospital care for ‘the simple dementing type of seniles’ who did not require psychiatric treatment.¹⁸³

¹⁷⁷ MoH, *Report for the year ended 31st March 1950* Cmd. 8342 (London: HMSO, 1951) 162, 316

¹⁷⁸ MoH, memo, ‘Care of the aged’ (SAC(MH)(49)4) Para 3 (TNA, MH 133/502)

¹⁷⁹ Eileen Brooke, ‘Recent progress in mental health statistics’ *Monthly Bulletin of the MoH* (1958) 14: 208-215 208

¹⁸⁰ Office of Health Economics (OHE), ‘UK resident population and projections by age group, 1948-2051’ 1.1 <http://www.ohe.org/page/health-statistics/access-the-data/demographics/data.cfm> accessed 17.1.2013

¹⁸¹ Denis Martin, *Adventure in Psychiatry* (Oxford: Bruno Cassirer, 1962) 18

¹⁸² *Ibid.* 13

¹⁸³ Eric Dax, Francis Reitman, ‘Hospitals for the aged and infirm’ *BMJ* (1946) i: 736

Many long-stay institutions were transferred to the EMS during the war, making them less accessible to older people, and bomb damage plus staff shortages reduced services. There were press reports of ‘some shocking cases of cruel exploitation or neglect of old people’ in institutions, including ‘a senile woman of 87 who has to be tied into bed’.¹⁸⁴ Press accounts risked giving sensational newsworthy perspectives; they were less likely to report good care which undoubtedly also existed.¹⁸⁵ One general practitioner (GP) criticised the complacency of the medical profession and public service administrators about the lack of nursing facilities for the ‘aged and infirm’. He noted that ‘restless senile cases’ placed huge stress on relatives caring for them at home, stating that ‘The responsible authority, if there be one, appears to be shrouded in the depths of officialdom’.¹⁸⁶

The NHS Act 1946¹⁸⁷ included little specific about mental health, and largely dealt with the technical and legal aspects of transferring facilities and care to the NHS.¹⁸⁸ However, a few points were directly relevant to older people. Previously, mentally ill younger people, especially those with disruptive symptoms, would probably have been admitted to mental hospitals, while frail, senile older people were often admitted to workhouses where they would have had even less assessment of their health needs than was routine in mental hospitals. Now, ‘Relieving officers of the poor law authority will no longer have any powers or duties with respect to persons of unsound mind’, and it would no longer be lawful to detain them in ‘a workhouse’.¹⁸⁹ Thus the NHS Act provided opportunities to improve clinical care for mentally unwell older people, although post-war austerity provided little scope for this.

¹⁸⁴ Anon. ““Old People” The Nuffield Foundation Report’ *Guardian*, 15.1.1947, 4

¹⁸⁵ Samson, *Old Age*

¹⁸⁶ Mungo Park, ‘Hospitals for the aged and infirm’ *BMJ* (1946) i: 549

¹⁸⁷ National Health Service Act 1946, 9 and 10 Geo 6, chapter 81

¹⁸⁸ MoH, *National Health Service Act 1946: provisions relating to the mental health services* (London: HMSO, 1948)

¹⁸⁹ *Ibid.* 18, 21

There was much administrative fragmentation before the NHS, and creating a new 'single integrated service, instead of perpetuating the evils of independent competition'¹⁹⁰ was seen as desirable. However, the NHS had a tripartite structure: general practice, the hospitals and local authority health care were organised separately, and local authority personal social services were separate from them. Thus to a certain degree the fragmentation remained. This particularly affected services for older people with multiple needs. Separate lines of responsibility, especially for different types of long-stay care had the potential to create financial wrangles; for example, the longer a patient was in a NHS funded hospital, the less financial responsibility fell on the shoulders of social services, and *vice versa*. In particular, in times of austerity, neither would be keen to use their own precious resources; older people could be caught between authorities with competing responsibilities and funding criteria. Despite attempts to define responsibilities, the borders between health and social care remained disputed.¹⁹¹ In addition, poor co-ordination between health and social care, and the fact that health care was free, but social care (whether domiciliary or institutional) was provided on a means-tested basis, further undermined streamlined transitions between different authorities.

Another hurdle for creating old age services was staff recruitment. Working on an old age ward was regarded within the nursing hierarchy as a punishment. Doreen Norton, who qualified as a nurse in 1946, later reflected that, when she volunteered to work on a chronic sick ward, colleagues thought she had done something wrong.¹⁹² To attract staff, Affleck proposed that chronic sick ward nurses should be paid at the higher salary rates earned by mental nurses,¹⁹³ although that had the drawback of confirming perceptions of the work as intrinsically unrewarding. Affleck commented in 1948:

¹⁹⁰ Gray and Topping, *Hospital Survey*, 6

¹⁹¹ Robin Means, Randall Smith, *The Development of Welfare Services for Elderly People* (Kent: Croom Helm, 1985) 170-172

¹⁹² Doreen Norton, interviewer Margot Jefferys (BLSA, 1991)

¹⁹³ Affleck, 'Psychiatric disorders' 45

There is probably less glamour and more distasteful duty attached to the nursing of chronic organic dementia cases than in any other branch of nursing.¹⁹⁴

This probably partly reflected the low value placed on them by society. Contrasting with that view, some acknowledged the professional and emotional rewards of providing care for older people; it is 'of absorbing interest to those who are in sympathy with the joys and trials of the aged'.¹⁹⁵

Compared with hospital services, the new NHS probably had a greater impact on the wellbeing of pensioners living in the community, providing access to GPs, medication, dental care, sight testing, chiropody and prescription spectacles, all initially free of charge. Concerning geriatric and psychogeriatric services, *When You are Old*,¹⁹⁶ a health education booklet published by the BMA about the new NHS, seemed over-optimistic. It extolled the virtues of the new geriatric medicine – assessment, active treatment and rehabilitation – then somewhat less optimistically mentioned the reality of obtaining them:

Geriatric departments are not entirely imaginary. There are actually two or three hospitals in this country which already have them, though this is, of course, only a drop in the ocean of what is needed.¹⁹⁷

It was also unrealistic about current staffing and training. For example, to help decide on care needs for people with 'mild senile dementia' it noted that 'Naturally, an expert psychiatrist would be called in'.¹⁹⁸

Perhaps the view in 1948 of Trevor Howell, a GP who became a geriatrician, was more realistic:

With old age today, the emphasis has been laid on the new geriatric units ... But every physician and surgeon who is treating elderly patients echoes the same cry: 'Why didn't we get these sooner'. The geriatric

¹⁹⁴ *Ibid.* 44

¹⁹⁵ Samson, *Old Age*, 51

¹⁹⁶ BMA, *When You are Old*

¹⁹⁷ *Ibid.* 8

¹⁹⁸ *Ibid.* 12

departments of the present resemble an Army base hospital. The damage has been done before the patient gets there. All of them have gone down the line, from hospital to hospital, before they come to the place in which serious treatment begins.¹⁹⁹

Older people with mental and physical disorders needed good access to prompt and specialist care which could manage the complexity of their multiple clinical and social needs. Howell and a handful of other interested clinicians conveyed this sense of urgency, but the authorities did little to respond. Facilities changed only slowly in chronic sick wards, in mental hospitals and in the provision of out-patient clinics and community and domiciliary services for older people and their families caring for them.²⁰⁰ Letitia Fairfield, a public health physician, commented in 1943 that ‘Problems raised by chronic sickness are important but have been neglected in most schemes for medical reorganisation’.²⁰¹ Her comment still rang true for the new NHS.

The new NHS was at times criticised as a ‘National *Hospital* Service’; acute intervention mainly for younger people was the dominant element.²⁰² Webster commented on the difficulties of developing health service provision for older people: competing welfare pressures such as those relating to younger families, ‘inertia within the system’, complacency, lack of leadership from the centre, and lack of pressure from below to achieve identified goals.²⁰³ Resources continued to be targeted at maintaining inefficient long-stay hospital accommodation, rather than at creating modern old age health services and ‘genuine care within the community’.²⁰⁴ Health care in old age, though, was not just a matter for professionals and the government: the BMA emphasised the need for an ‘awakening of the whole community to the existence in their midst of a state of affairs often tragic in its melancholy and suffering’.²⁰⁵

¹⁹⁹ Trevor Howell, ‘Old age in general practice’ *PRSM* (1948) 41: 337

²⁰⁰ Webster, ‘The elderly’ 187-188

²⁰¹ Letitia Fairfield, ‘Care of the chronic sick’ *Lancet* (1943) ii: 455-457 455

²⁰² Webster, *Political History*, 38

²⁰³ Webster, ‘The elderly’ 187

²⁰⁴ *Ibid.* 187-188

²⁰⁵ BMA, *Care and Treatment*, 26

Community surveys: Rowntree and Sheldon

The prevalence of mental disorders in old age could not be determined from hospital data. Many patients entered institutional care at an advanced stage of dysfunction. Others with dementia probably died from acute illnesses before becoming sufficiently impaired to require chronic sick ward or mental hospital admission.²⁰⁶ Thus community studies were required to ascertain need and the prevalence of the disorders.

Two studies were undertaken. The first (1944-45), by a Committee of the Nuffield Foundation headed by Benjamin Seebohm Rowntree (1871-1954), had a largely social and domestic focus. It comprised 2,302 people (women over 60, men over 65), randomly selected in four localities, with stratified samples in two others. The samples were considered representative of urban and rural England and Wales.²⁰⁷ The second (1945-47) was based on the random sample of 477 people in the Wolverhampton part of Rowntree's study; Dr Joseph Sheldon (1893-1972), director of medicine at the Royal Hospital, Wolverhampton, investigated the health of older people living in the community.²⁰⁸

Rowntree's study

Rowntree's report concluded that 95% of older people lived in the community, not in institutions. Many of them were leading independent lives, although some were struggling to maintain that independence.²⁰⁹ Rowntree identified the needs of older people, including for practical help, domiciliary physiotherapy and clubs to counteract loneliness.²¹⁰ Existing provision was insufficient. Home-help services, some established during or just after the Second World War,²¹¹ were patchy, partly due to lack of available workers.²¹²

²⁰⁶ Stengel, 'Symptomatology' 1

²⁰⁷ Rowntree, *Old People*, 4-5

²⁰⁸ Sheldon, *Social Medicine*, 6

²⁰⁹ Rowntree, *Old People*, 95

²¹⁰ *Ibid.* 49-54

²¹¹ EMA Wilson, 'The home helps scheme in Leicester' *Nursing Mirror*, 11.12.1948, ii-iv ii

²¹² Rowntree, *Old People*, 49; Means and Smith, *Welfare Services*, 87-99

Subsidised meals which had been provided by British Restaurants in war time were ending.²¹³ Adequate support for families caring for dependent older people was also needed: ‘a burden cheerfully born still remains a burden’, commented Rowntree.²¹⁴ For some people, inadequate service provision amounted to severe neglect:

aged persons dying in circumstances of great squalor and loneliness because local authorities, although asked, have been unable to fulfil their legal obligations to receive them into an Institution.²¹⁵

Rowntree, like Andrews in Cornwall,²¹⁶ advocated medical assessment in general hospitals to ensure that people were not admitted to chronic wards unless absolutely necessary. Like Lewis, Post and the geriatricians, he emphasised ‘diagnosis and treatment’.²¹⁷ He recommended that various forms of accommodation should be provided, including the ‘ordinary Home under a good Matron’,²¹⁸ and separate ‘institutions for senile demented’.²¹⁹ The report also suggested that institutions should train staff to care for frail and unwell older people, including those suffering from ‘a measure of senility’.²²⁰

Sheldon’s study

Sheldon’s study was unusual. It was a large, randomly selected sample specifically to investigate mental and physical health, rather than social and domestic circumstances, among older people living at home rather than in institutions. It complemented Goldschmidt’s community study on social factors and mental health.²²¹

²¹³ Rowntree, *Old People*, 50

²¹⁴ *Ibid.* 47

²¹⁵ *Ibid.* 63

²¹⁶ Truro Public Assistance Committee, 39 (BGSA)

²¹⁷ Rowntree, *Old People*, 73

²¹⁸ *Ibid.* 73

²¹⁹ *Ibid.* 76

²²⁰ *Ibid.* 102

²²¹ Goldschmidt, ‘Social aspects’ 182

The questionnaire designed to assess mental health had been devised by Lewis,²²² a member of Rowntree's committee.²²³ Despite Lewis's expertise in mental health, his questionnaire for assessing older people was not ideal. Sheldon commented:

while most people are quite prepared to discuss their intellectual state over such questions as memory and activity, few will accept questions relating to habits ... there would be no guarantee of an accurate answer, since, apart from other considerations, the subject would often be quite unconscious of the fact.²²⁴

Lewis's questionnaire indicated that even some experts lacked the practical skills needed to assess the mental wellbeing of older people.

Concerning mental conditions, Sheldon concluded that 82% of his sample were 'normal', 11% had 'faculties slightly impaired' and 4% were 'demented, forgetful or childish and difficult to live with'. A few of normal intellectual function he categorised as 'eccentric in habits'. They might be solitary, aggressive or 'paranoid' which he linked to 'an over-development of the theme of personal independence'.²²⁵ As was common, Sheldon's classification appeared to be his own and based upon the intensity of the individual's symptoms, rather than on an accepted diagnostic system. Despite this limitation, his conclusions appeared valid. The small number of older people who were 'difficult to live with' had major implications for the wellbeing of their families or others living with them. He likened the role of long-term carers to 'working in a sweated industry', and stated that any scheme for improving old age care must include supporting carers.²²⁶ This point was also made by Rowntree²²⁷ and corroborated Lewis and Goldschmidt's observation that social rather than medical crises often precipitated admission to hospital.²²⁸

²²² Sheldon, *Social Medicine*, vii, 9

²²³ Rowntree, *Old People*, vii

²²⁴ Sheldon, *Social Medicine*, 110

²²⁵ *Ibid.* 126-127

²²⁶ *Ibid.* 197

²²⁷ Rowntree, *Old People*, 47

²²⁸ Lewis and Goldschmidt, 'Social causes' 95, 96

Sheldon was positive about the older people he interviewed, admiring their ‘mental vigour and “guts”’, and concluded that ‘living in the environment they are used to, of having something to do, and of being still able to feel necessary to the world’ were important for their wellbeing.²²⁹ His study indicated that most community dwelling pensioners were mentally healthy, not decrepit individuals dependent on society. Post commented on Sheldon’s study:

It is reassuring to have confirmation, scientifically obtained, of the impression gained in everyday contact with old people, that the overwhelming majority retain their mental faculties to the full.²³⁰

This was an important message for health and social care authorities, much needed to counteract common negative assumptions.²³¹ In addition, Sheldon suggested that older people should be ‘permitted to wear out and not rust out’,²³² similar to Amulree’s message ‘Don’t mollycoddle old people’.²³³ Encouraging activity and independence for older people contrasted with the more common view of their neediness, passivity and dependence.

Concerned committees: the BMA and the MH-SAC

After the war, the BMA and the MH-SAC considered the wellbeing of older people. Concerning mental health, Lewis was the link between them and Rowntree’s and Sheldon’s studies.

The BMA committee on the care and treatment of the elderly and infirm

The BMA committee, established in 1946, included geriatricians Amulree, Cosin, Warren and Eric Brooke (a pioneer of geriatric domiciliary assessments²³⁴), a nurse, an almoner and public health and local government

²²⁹ Sheldon, *Social Medicine*, 108

²³⁰ Felix Post, ‘Mental aspects of senescence’ *British Medical Bulletin* (1949) 6: 54-57 54

²³¹ Mass Observation, ‘Old Age’, *Mass Observation Bulletin* (Oct.-Nov. 1948) 21: 1-4

²³² Joseph Sheldon cited in: Anon. ‘BMA Annual Meeting’ 103

²³³ Anon. ‘Don’t mollycoddle old people’ *Evening Standard*, 5.1.1948, 3, citing Amulree

²³⁴ Eric Brooke, ‘Care of the old in their homes’ *Lancet* (1949) i: 462

representatives.²³⁵ Including a psychiatrist was not discussed until the first meeting, supporting the view that psychiatrists were not automatically regarded as integral to the care of older people. The committee invited Lewis to join, or someone delegated by him.²³⁶ Lewis recommended Eric Guttmann, another Maudsley psychiatrist. Guttmann's textbook, *Psychological Medicine*, stated the conventional view that senile dementia was 'an exaggeration of the usual psychological changes of old age'²³⁷ rather than an illness. The committee minutes record no contributions from Guttmann.

With four pioneering geriatricians, it is hardly surprising that the emphasis was predominantly on geriatric departments, which 'should be responsible for diagnosis of all elderly sick, whether acute or chronic'.²³⁸ This included providing 'observation wards for investigation and general treatment of older psychiatric patients other than those needing admission to mental hospital',²³⁹ since older patients should only be admitted to mental hospitals if they were likely to benefit from 'the active treatment provided in modern hospitals of this kind'.²⁴⁰ Geriatricians appeared to be the only medical professionals who wanted to work with older people. Others, including psychiatrists, appeared grateful for this.

The diagnostic, treatment and accommodation needs of older mentally unwell patients were addressed in the BMA committee's report (Fig 5). It recommended assessment and diagnosis by a psychiatrist on the geriatric ward. Only then should decisions be made for transfer to long-term care or to a mental hospital. Due to the stigma attached to mental hospital certification, it was thought humane to avoid the legal route to admission if at all possible,

²³⁵ BMA, *Care and Treatment*, 4

²³⁶ BMA, Committee on the Care and Treatment of the Elderly and Infirm, minutes, 4.12.1946, 8.2 (BMAA)

²³⁷ Desmond Curran, Eric Guttmann, *Psychological Medicine: a short introduction to psychiatry* (Edinburgh: E and S Livingstone, 1949) 85

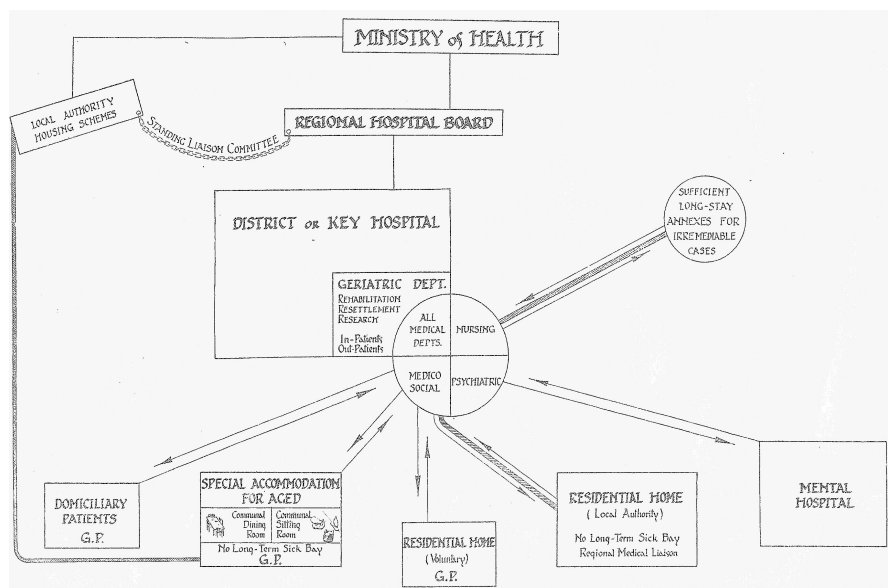
²³⁸ Marjory Warren, Eric Brooke, Lionel Cosin, 'Précis of a meeting to discuss "Problems of the chronic sick"' 16.5.1946 (BMAA, Committee on Care and Treatment)

²³⁹ Marjory Warren, Eric Brooke, Lionel Cosin, 'A coordinated medical service for the elderly' 21.4.1947 (BMAA, Committee on Care and Treatment)

²⁴⁰ BMA, *Care and Treatment*, 10

especially for 'simple senile dementia'.²⁴¹ Long-stay annexes located close to families and friends were suggested for the “20% residuum” of irremediable patients'.²⁴² In addition, education for staff, collaboration with social workers and GPs and facilities for research into geriatric medicine and gerontology were recommended.²⁴³ Based on existing social and medical evidence, the plans were as sound as possible.

Fig 5. The BMA plan for older people, 1947



Source: BMA, *Care and Treatment*, 19 (Reproduced with permission from BMA)

The committee's recommendations, however, embodied several difficulties. Collaboration between geriatricians and psychiatrists was suggested, but only on geriatric wards.²⁴⁴ With little interest shown by psychiatrists in older people, it appeared unlikely that they would be enticed easily onto geriatric wards. Without proposals for reciprocal arrangements in the mental hospitals, there would be an unequal relationship between the specialists, with psychiatrists expected to support the geriatricians but not *vice versa*. No evidence has been identified suggesting that psychiatrists approached the municipal hospitals to assist in the management of disturbed or demented patients, or that geriatricians

²⁴¹ *Ibid.* 10

²⁴² *Ibid.* 22-23

²⁴³ *Ibid.* 18

²⁴⁴ *Ibid.* 10

were enthusiastic about working in mental hospitals. In part, that may have been due to shortages of geriatricians and psychiatrists,²⁴⁵ but perhaps it also reflected their priorities. Importantly, the geographic separation of the typical rural mental hospitals from the usually urban municipal hospitals was not conducive to regular collaboration. However, transport difficulties could have been overcome if there had been the will to collaborate.

The Mental Health Standing Advisory Committee

The MH-SAC was an independent, critical voice within the NHS advisory machinery, recognised as having members committed to improving mental health provision. According to Webster, it made a determined effort to influence events.²⁴⁶

The MH-SAC was asked specifically by the Minister of Health to advise on older people.²⁴⁷ Its proposals were similar to those of the BMA; geriatric departments in general and teaching hospitals should have observation wards allowing for assessment of psychiatric disorders.²⁴⁸ It also supported long-stay care annexes attached to geriatric departments or mental hospitals, but recognised that co-locating them with mental hospitals meant that residents would remain at a significant distance from their families, friends and previous neighbourhoods. Thus, in order to accommodate older people in their own neighbourhoods, and to ‘overcome the difficulty experienced ... of recruiting nurses to care exclusively for aged patients’, they recommended having the annexes based locally but with links to the parent institution for training and staffing.²⁴⁹ It is difficult to ascertain how much this practical proposal was implemented.

²⁴⁵ Affleck, ‘Psychiatric disorders’ 43-44

²⁴⁶ Charles Webster, ‘Psychiatry and the early National Health Service: the role of the Mental Health Standing Advisory Committee’ 103-116. In: *150 years* ed. Berrios and Freeman, 103

²⁴⁷ MH-SAC, ‘Remit: Care of the aged’ (1949) Para 6 (TNA, MH 133/502)

²⁴⁸ BMA, *Care and Treatment*, 22; MH-SAC, report of second meeting (1949) Para 2 (TNA, MH 133/502)

²⁴⁹ MH-SAC, report of second meeting (1949) 5.iv. (TNA, MH 133/502)

The recommendations of the BMA and the MH-SAC were subsequently codified by the Ministry of Health in 1950 in *Care of the Aged Suffering from Mental Infirmary*²⁵⁰ and *Treatment of the Elderly Chronic Sick*.²⁵¹ The titles themselves revealed attitudes and expectations: passive ‘care’ for mental difficulties, and active ‘treatment’ for physical disorders. Lewis had attended the MH-SAC meetings where older people were discussed.²⁵² It is therefore hard to believe that he was unaware of their recommendations or of these circulars. Nevertheless, Lewis’s Geriatric Unit at the Bethlem-Maudsley functioned without geriatricians or a long-stay annexe. It excluded people with organic disorders and aimed only to treat people with potentially reversible functional mental illness. Its radical approach to diagnosing and treating older people differed significantly from standard practice in the mental hospitals. Deviating from mainstream recommendations, Lewis’s plans fitted with the reputation of the Bethlem-Maudsley for being elitist and dissociated from real practice, which might have contributed to undermining its credibility in mental hospitals elsewhere, at least with respect to older people.

In summary, there were two parallel streams of NHS development for psychogeriatric services; the recommended geriatric-led model in general hospitals and in one teaching hospital, and Lewis’s academic approach and functional illness model in a psychiatric teaching hospital. This dichotomous approach risked neglecting the mental hospitals and ‘senility’ in the community where significant concerns were centred. Neither Lewis’s nor the Ministry’s schemes comprehensively addressed the needs of mentally ill older people.

Economics: the deluge of demand

Rowntree cautioned: ‘the burden of maintaining the aged may become so great as to result in a lowering of the national standard of living’,²⁵³ a view also held by the Royal Commission on Population²⁵⁴ and many in wider society.²⁵⁵

²⁵⁰ MoH, *Care of the Aged Suffering from Mental Infirmary* HMC(50)25 (1950)

²⁵¹ MoH, *Treatment of the Elderly Chronic Sick* HMC(50)38 (1950)

²⁵² MH-SAC, meetings, 1949-51 (TNA, MH 133/497)

²⁵³ Rowntree, *Old People*, 2

²⁵⁴ *Report of the Royal Commission on Population*, 113

Rowntree commented that supporting people in their own homes might be more expensive than admission to institutional care.²⁵⁶ This would not be surprising given the communal living arrangements and economies of scale in many institutions. However, the risk of increased expenditure may have diminished the potential impact of his and Sheldon's studies. Rowntree's study was discussed in the House of Lords by Amulree, but neither Sheldon's nor Rowntree's study was discussed in the House of Commons.²⁵⁷ The National Archives provides no evidence that either study stimulated interest at the Ministry of Health similar to the bed-emptying, perceived cost-cutting achievements, of the hospital based geriatricians.

Sir Ernest Rock Carling (1877-1960), retired surgeon, pioneer of radiotherapy²⁵⁸ and member of the BMA committee,²⁵⁹ criticised the lack of humanity in providing for older people:

Even the most enlightened public assistance authorities have assumed that a lower grade of building, inferior medical and nursing skill, a lower standard of nourishment, and few amenities will suffice for the 'chronic sick' than for other classes of patients. How comes it that this practice has been tolerated...?²⁶⁰

Fears of the excessive costs of providing adequately for chronic sick, mainly older, people might have been associated with this sort of neglect. Economic factors were unavoidable, and in the post-war financial climate, suggestions which might increase expenditure were unlikely to stimulate government activity. However, only the cost of care seemed to be considered; the potential economic benefits of keeping older people healthy and contributing to, or less dependent upon, society were overlooked. As Sheldon identified, most older

²⁵⁵ Mass Observation, 'Old Age' 2

²⁵⁶ Rowntree, *Old People*, 49

²⁵⁷ Lord Amulree, 'Plight of old people' HL Deb 1.5.1947 *Hansard* Vol. 147 cc336-68 <http://hansard.millbanksystems.com/lords/1947/may/01/plight-of-old-people> accessed 13.9.2012

²⁵⁸ Stanford Cade, 'Carling, Sir Ernest Rock (1877-1960)', *ODNB*, OUP, 2004 <http://www.oxforddnb.com/view/article/32290> accessed 21.3.2013

²⁵⁹ BMA, *Care and Treatment*, 4

²⁶⁰ Ernest Rock Carling, 'The chronic sick: proper care for the aged and infirm, hospitals for protracted illness' *Times*, 25.11.1946, 5

people were well, but the relatively small proportion requiring care dominated society's perspective.

The BMA report proposed that 'the most energetic measures possible should be adopted to improve existing conditions with a minimum of delay'.²⁶¹ However, it also contained an unfortunate, although probably realistic, caveat, without further explanation:

progress in achieving an improved medical service for the elderly will inevitably be slow. Many years must pass before any scheme such as is advocated here can be brought fully into operation throughout the country.²⁶²

A similar message was incorporated into the Ministry's circular, *Care of the Aged Suffering from Mental Infirmary*: 'present conditions of financial stringency limit opportunities for action at this time'.²⁶³ This was not included in its physical illness companion, *Treatment of the Elderly Chronic Sick*,²⁶⁴ suggesting that plans for physical and mental health provision were inequitable.

The caveats removed any sense of urgency or impetus for implementation: older people, especially if mentally unwell, could wait. The needs of older people and others with chronic disabilities who were perceived as unlikely to regain an economic role in society were relegated to second best. The deluge of demand for dentures, spectacles and hearing aids when the NHS commenced probably added to the notion of almost unsustainable demands for resources,²⁶⁵ although this demand mainly reflected the lack of support for chronic illness before the NHS for those unable to pay the charges. There was no comparable demand for in-patient facilities. There are various explanations for this, including that: it was not needed; older people realistically feared that once admitted to hospital they would never leave; and GPs did not refer older people

²⁶¹ BMA, *Care and Treatment*, 26

²⁶² *Ibid.* 26

²⁶³ MoH, *Care of the Aged*, 2

²⁶⁴ MoH, *Treatment of the Elderly*

²⁶⁵ Webster, *Political History*, 29

or hospitals refused to admit them.²⁶⁶ Nevertheless, the possibility of ‘thousands and thousands of old people ... demanding urgent admission when they hear there may be hope for them’ was suggested in *When You are Old*.²⁶⁷ This would have been most hospital administrators’ and doctors’ nightmare. Post-war austerity probably contributed to implementation delays within the NHS generally, such as for building new hospitals. However, providing better geriatric services within existing hospitals might have been feasible since geriatric medicine aimed to improve and discharge patients and vacate beds. Alternatively, in conjunction with the anxiety over the economic ‘burden’, fears of overwhelming demand might have contributed to inhibiting widespread improvements: it was easier for authorities to do nothing than to begin to create new services and feel out of control clinically and financially.

Conclusions

Older people still tolerated poverty and impairment and were largely absent from initiating changes in health care. Entrenched fears of the mental hospitals, chronic sick wards and the Poor Law probably discouraged them from seeking assistance.

The importance of domestic circumstances in precipitating mental hospital admission was evident, but little was obtainable to alleviate social conditions or support families. Admissions of older people to mental hospitals increased. Those patients were doubly forgotten, geographically in the countryside and then in the often overcrowded and un-therapeutic back wards.

The new geriatricians were optimistic about treating and rehabilitating older physically unwell people. Concerning old age mental disorders, fresh ideas materialized, notably from Mayer-Gross, Lewis, Post and Sheldon. However, they did not capture the attention of the Ministry of Health or inspire psychiatrists to work more constructively with older people in most mental hospitals.

²⁶⁶ Trevor Howell, ‘The problem of the chronic sick’ *Medical Press* (1951) 225: 505-507 505

²⁶⁷ BMA, *When You are Old*, 13

Various factors probably influenced the lack of development of psychogeriatric provision: competing post-war priorities and austerity; lack of public pressure; no ministerial encouragement; less evidence of clearing beds compared to geriatric medicine; embedded stereotypes of the impossibility of recovery from mental disorder in old age; and general prejudices against both mental illness and older people. Demographic changes might have acted as a spur to helping older people. Instead, fear of the overwhelming impossibility of achieving adequate provision for a growing older population might have held back change. Permissive guidelines and waiting for an economically secure time to improve services for older people's health care appeared to create a self-fulfilling prophecy of under-provision. Nevertheless, there was some acknowledgement in professional and government circles that age-appropriate psychiatric services were necessary.

Chapter 2

Greater knowledge but little impact in the 1950s

There is no more interesting symptom than mental confusion in the elderly.

Professor Sir William Ferguson Anderson, 1956¹

Introduction

Psychiatric practice for all age groups shifted in the 1950s, linked to biological psychiatric research and national policy initiatives. Changes included new psychopharmacology, mental hospital ‘open door’ policies, community care and a Royal Commission leading to the Mental Health Act (MHA) 1959.² Kathleen Jones, in her analysis of mental health policy, commented that the concurrence of these changes was fortunate as each significantly reinforced the other.³ Even before these changes, social expectations and fresh concepts of mental illness had affected treatment, mainly for younger people. The influential nineteenth century ‘degeneration’ theory of hereditary and irreversible mental disorders inevitably declining into chronic impairment requiring custodial care, shifted during the First World War to a model of treatable illness.⁴ ‘Community care’ originated in the work of the Mental After-Care Association founded in 1879⁵ and was taken up in the Wood Report (1929) on mental deficiency.⁶ Out-patient clinics and the voluntary status of in-patients introduced by the MTA (1930) began to affect admission and discharge patterns even before the introduction of effective psychopharmacological treatments.

¹ William Ferguson Anderson, ‘Difficulties in the management of sick old people’ *Medical Press* (1956) 236: 341-345 343

² *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (Percy Report) Cmnd. 169 (London: HMSO, 1957)

³ Jones, *Asylums and After*, 149

⁴ Daniel Pick, *Faces of Degeneration: a European disorder, c.1848-c.1918* (Cambridge: CUP, 1989) 17

⁵ Alexander Walk, ‘Psychiatry in the 1870s: centenary of the Mental After-Care Association’ *Psychiatric Bulletin* (1979) 3: 122-123

⁶ *Mental Deficiency Committee* (Wood Report) Part iv (London: HMSO, 1929) 153-154

In society more broadly, public education initiatives aimed to reduce the stigma of mental illness. However, old age disorders were virtually absent from that material.⁷ For example, the television series *The Hurt Mind* (1957) optimistically explored modern psychiatric treatments, but ignored older people.⁸ Member of Parliament (MP) Kenneth Robinson addressed the Association of Psychiatric Social Workers in 1957, referring to two small surveys about attitudes to mental illness. They revealed a public 'more knowledgeable, more sympathetic and less prejudiced than one might have expected'. Even so, one in five admitted to fear of people with mental illness and only half would employ a person having out-patient treatment. Four out of five believed that 'the mentally ill can be cured, with doubts about the older patient'.⁹ Although these statements were vague and details of the original surveys were not stated, if old age disorders were considered less curable, the implication was that sufferers required more 'care' and less 'treatment'.¹⁰ This added to other observations confirming the established pattern of different expectations for older and younger patients.¹¹

Community care aimed to prevent admission and enable rapid discharge. However, psychiatric teaching remained that admission to mental hospital was an essential component of treating serious psychiatric disorders. Any new hypothesis would need testing. This was the objective of the 'Worthing experiment' in Sussex, providing community alternatives for all adult age groups.¹² This major study was organised by the NHS South West Metropolitan Regional Hospital Board (RHB) with financial support from the NPHT. Significantly, the number of people aged over 65 in the study was

⁷ David Stafford-Clark, *Psychiatry To-day* (Harmondsworth: Penguin Books, 1952); Henry Yellowlees, *To Define True Madness* (Harmondsworth: Penguin Books, 1953)

⁸ BBC, *The Hurt Mind* (1957) British Film Institute <http://ftvdb.bfi.org.uk/sift/title/10718?view=synopsis> accessed 25.9.2010

⁹ Kenneth Robinson, 'Public attitudes to mental disorder' *British Journal of Psychiatric Social Work* (1957) 4: 28-29

¹⁰ Means and Smith, *Welfare Services*, 188

¹¹ WHO, *Mental Health Problems of Aging and the Aged* (Geneva: WHO, 1959) 10

¹² Joshua Carse, Nydia Panton, Alexander Watt, 'A district mental health service: the Worthing experiment' *Lancet* (1958) i: 39-41

substantial (318 of 1192, 26%).¹³ Most had functional disorders. With community interventions, admission in that group fell from 169 in 1956 to 90 in 1957.¹⁴

Psychiatrists participating in the study commented that the cultural re-orientation necessary for them to move from a hospital to a community setting was difficult.¹⁵ For a community approach to become effective policy, widespread similar cultural and organisational shifts were needed. That was a tall order. Innovative thinking and culture change may have been particularly difficult to achieve in mental hospitals; some staff were perhaps attracted to work in them because they felt comfortable with their typically hierarchical, regimented organisational structure and authoritarian management style.

The Labour Party, which had been in government since 1945, lost the general election in 1951. Throughout the rest of the 1950s, a Conservative government was in power. They were not always united in support of a universal welfare scheme, some advocating the basic tenets of nineteenth century *laissez-faire*.¹⁶ Moves away from a universal health policy affected the least well off, including older people. This can be illustrated by the introduction of prescription charges in 1952. These charges, (albeit proposed by the previous Labour government), started at one shilling (5p) per *form*; pensioners were not exempt.¹⁷ This became more problematic in 1956 when charges rose to one shilling per *item*.¹⁸ With inadequate pensions and chronic physical conditions occurring more frequently at older ages, this particularly discriminated against older people relying on state benefits.

¹³ *Ibid.* 39

¹⁴ *Ibid.* 40

¹⁵ *Ibid.* 40

¹⁶ Paul Bridgen, Rodney Lowe, *Welfare Policy under the Conservatives, 1951-1964: a guide to documents in the Public Record Office* (London: PRO c.1998) 9-10

¹⁷ William Keenan, Iain Macleod, 'Prescription charges' HC Debate 19.6.1952 *Hansard* Vol. 502 cc1530-3 http://hansard.millbanksystems.com/commons/1952/jun/19/prescription-charges-assistance#S5CV0502P0_19520619_HOC_41 accessed 8.6.2012

¹⁸ Victor Collins, 'Prescription charges' HC Debate 12.11.1956 *Hansard* Vol. 560 cc535-7 <http://hansard.millbanksystems.com/commons/1956/nov/12/prescription-charges> accessed 20.5.2010

In 1954, there were approximately five million people over 65 years in England and Wales, one in nine of the population, compared to one in 21 in 1901.¹⁹ The birth-rate increased in the 1950s, helping to diminish the panic of the ‘menace’ of an ageing population,²⁰ although the government still had concerns about providing for older people.²¹ Various documents about the physical and mental health of older people emerged nationally²² and internationally.²³ WHO’s comprehensive, pragmatic and far sighted report *Mental Health Problems of Aging and the Aged* in 1959 reiterated the need for short term assessment admissions, active treatment, rehabilitation and maintaining people in their own homes.²⁴ The WHO report, like others from reputable bodies such as the National Old People’s Welfare Council,²⁵ created little public interest or government activity to implement recommendations.

A few psychiatrists took an interest. Among them, Martin Roth classified mental disorders²⁶ and Ronald (Sam) Robinson established a comprehensive ‘diagnostic and treatment unit for the aged in a mental hospital’.²⁷ This chapter seeks to explore their contributions and other innovations and changes relating to providing psychogeriatric services during the 1950s.

¹⁹ MoH, *Survey of Services Available to the Chronic Sick and Elderly 1954-55* (Boucher Report) (London: HMSO, 1957) 3

²⁰ Thane, ‘Declining birth-rate’

²¹ Boucher Report, 3-5

²² MoH, *Geriatric Services and the Care of the Chronic Sick* HM (57)86 (London: MoH, 1957); *Committee on the Economic and Financial Problems of the Provision for Old Age* (Phillips Report) Cmd. 9333 (London: HMSO, 1954)

²³ WHO, *Problems of Aging*

²⁴ *Ibid.* 32-47

²⁵ National Old People’s Welfare Council, *Notes on Mental Frailty in the Elderly* (London: National Council of Social Services, 1958)

²⁶ Martin Roth, John Morrissey, ‘Problems in the diagnosis and classification of mental disorder in old age: with a study of case material’ *JMS* (1952) 98: 66-80; Roth, ‘Natural history’

²⁷ Ronald (Sam) Robinson, ‘The organisation of a diagnostic and treatment unit for the aged in a mental hospital’ 186-205. In: World Psychiatric Association (WPA), *Psychiatric Disorders in the Aged* (Manchester: Geigy, 1965)

Older people in the mental hospitals

The existing picture and the need for change

Mental hospital beds in England and Wales reached a peak of 148,000 in 1954.²⁸ Severe overcrowding, with beds in corridors and down the middle of Nightingale wards, needed to be remedied.²⁹

A report in the *Guardian* about the annual conference of the Association of Hospital Management Committees cited one delegate's view, that mental hospitals 'should be regarded as treatment centres for the mentally ill and not as depositing grounds for the senile for whom nothing can be done'.³⁰ 'Done' implied active or ameliorative treatment. The very presence of older people in mental hospitals was deemed, by some psychiatrists, to undermine care for those 'more in need of active treatment, having to be denied admission',³¹ i.e. younger people. Ideas emerging within geriatric medicine, of accurate diagnosis, actively relieving symptoms, improving quality of life, supporting families and providing day and respite care,³² had not permeated mental hospital practice.

Admission rates were increasing at all ages, but for younger people duration was shorter. For them, some of the increase was probably due to brief re-admissions; the former long-stay patient was becoming chronically ill in a different, 'revolving door' sense.³³ Rates of first admissions, however, increased with age, and were consistently higher for women than men (Table 2). Many factors probably influenced these rates for both sexes, including low expectations of recovery and established patterns of social and psychiatric care. For women, admission may also have been influenced by having smaller financial resources available, especially if they were previously unemployed

²⁸ Eileen Brooke, 'Factors affecting the demand for psychiatric beds' *Lancet* (1962) ii: 1211-1213

²⁹ Kathleen Jones, 'The culture of the mental hospital' 17-28. In: *In 150 years* ed. Berrios and Freeman, 25

³⁰ Anon. 'Caring for the senile "Half-way homes"' *Guardian*, 13.6.1958, 14

³¹ RMPA, Geriatric Committee, 'Report' (1951) 1 (RCPsychA)

³² Cosin (BLSA)

³³ Brooke, 'Demand for psychiatric beds' 1211

and un-married, and greater longevity, ultimately associated with living alone, difficulty coping with frailty and illness, and therefore requiring additional health and welfare support.

Table 2. Mental hospital first admission rates per 100,000 population, 1951 and 1960

	55-64 years	65-74 years	75+ years	All ages ^a
Males				
1951	113	151	251	79
1960	151	198	349	109
Females				
1951	132	161	277	99
* 1960	177	228	391	146

a. 15 years and over in 1951, 16 years and over in 1960

Source: *The Registrar General's Statistical Review of England and Wales for the Year 1960: supplement on mental health* (London: HMSO, 1964) 7

In 1955 almost one third of mental hospital in-patients in England and Wales were over 65 years (46,300 of 146,900)³⁴ compared with one quarter in 1948,³⁵ and 27.5% (39,843 of 144,606) in 1950.³⁶ A study by psychiatrist Alan Norton at Bexley Hospital, Kent, indicated that, of those who remained in hospital for two years, 16% were over 65 years in 1928-30, compared with 55% in 1957,³⁷ markedly disproportionate to demographic trends. This contrasted with his findings about admissions for people with schizophrenia, a disorder which generally starts at a young age and runs a chronic course. For those patients, Norton found that the mean duration of admission fell from seven months to under two months, and those staying in hospital for over two years fell from 41% to 19%.³⁸ Unfortunately, additional, comprehensive, directly comparable data for different dates and places are not readily available.

³⁴ Brooke, 'Recent progress' 209

³⁵ MoH, memo, 'Care of the aged' (SAC(MH)(49)4) Para 3 (TNA, MH 133/502)

³⁶ MoH, *On the State of the Public Health, being the Annual Report of the Chief Medical Officer for the Year 1950* Part 2. Cmnd. 8582 (London: HMSO, 1952) 137

³⁷ Alan Norton, 'Mental hospital ins and outs: a survey of patients admitted to a mental hospital in the past 30 years' *BMJ* (1961) i: 528-535 534

³⁸ *Ibid.* 531

Despite a universal health and welfare system and the recognized effectiveness of treatment and rehabilitation for physically unwell older people, they continued to be admitted to mental hospitals. Since 1948 there had been reports about the difficulties of arranging admission to general hospitals for older people.³⁹ General hospital consultants feared older people ‘clogging’⁴⁰ beds. Those consultants were largely responsible for the financial management of their hospitals. They may not have wanted to treat older patients, but nor did they want to provide resources for others to do so. Rather than improve facilities and treatment for older people in general hospitals, the preferred option appeared to be to exclude them.⁴¹ Once excluded from general hospitals, alternatives were mental hospitals or chronic sick wards. Stigmatising terminology cruelly blamed older people for the inadequacy of services: mental hospitals were “‘choked” by the admission of this type of patient’⁴² and geriatric rehabilitation beds were ‘blocked by cured cases’,⁴³ reflecting the ‘burden of those old people’.⁴⁴

Mental hospitals did not welcome older people, as Brice Pitt (qualified in medicine 1955, later professor of old age psychiatry) described:

Even my very good mentor had the attitude that a good registrar did not admit an old person. A bad registrar did ...
The hospital ... was like a castle, a good registrar would fend off the elderly, as those who got in were bound to stay, bound to be dumped by their family.⁴⁵

³⁹ Anon. ‘No room at the hospital’ *Lancet* (1948) ii: 977

⁴⁰ Howell, ‘Chronic sick’ 505

⁴¹ Martin, ‘Medical knowledge’ 450

⁴² Bristol Local Medical Committee, *Report on the Treatment and Care of the Elderly Chronic Sick in Bristol* (Bristol: Bristol LMC, 1953) 34

⁴³ Boucher Report, 27

⁴⁴ J Bickford, ‘The forgotten patient. i. The problem reviewed’ *Lancet* (1955) ii: 917-919 917

⁴⁵ Brice Pitt, interviewer Margot Jefferys (BLSA, 1991)

Older people often by-passed the assessment wards and were admitted directly to long-stay back wards.⁴⁶ Their potentially reversible physical and psychiatric disorders often remained undiagnosed.⁴⁷ Psychiatrist Alwyn Lishman (qualified 1956, later professor of psychiatry), commented:

every large mental hospital had a secret large ward tucked away – perhaps three or four ... which were not much visited because they were full of old demented people. Because there was no interest in them, it fell to the most junior doctor to go there once a week to see if any one needed to have their chest listened to. The most neglected parts of any mental hospital were the old age wards.⁴⁸

The grudging medical attention given on the back wards contrasted with younger people's wards, which became hotbeds of intervention such as for treatment with new medications⁴⁹ and methods of rehabilitation.⁵⁰

Inadequate care in old age appeared to be ignored and there was little public outcry.⁵¹ Russell Barton, medical superintendent at Severalls Hospital, Colchester, in an oral history interview alleged rough handling and physical abuse: 'there are often pillows pushed over their faces and things'.⁵² Poor quality nursing was not conducive to optimising the patients' wellbeing, as one assistant nurse on a dementia ward indicated:

many of the nurses were silly, noisy, disagreeable women, sorely in need of a draught to quieten them down. 'Don't you waste time bothering with that b....y old bitch' one of them shouted at me one day as I was filling in a few spare moments chatting to a pleasantly deluded old woman.⁵³

⁴⁶ Ronald (Sam) Robinson, 'Witness' 8

⁴⁷ WHO, *Problems of Aging*, 10

⁴⁸ W Alwyn Lishman, interviewer Margot Jefferys (BLSA, 1991)

⁴⁹ Shorter, *History of Psychiatry*, 246-262

⁵⁰ Martin, *Adventure*

⁵¹ Webster, 'The elderly' 184-188

⁵² Russell Barton, interviewer Diana Gittins (1995) transcript, 53 (Wellcome Library, WL/GC/244/2/19)

⁵³ A mental hospital nurse, 'Patience and nurses' *Guardian*, 1.5.1957, 5

Mental nursing generally was in crisis, with poor recruitment and 'high wastage'.⁵⁴ During general and mental nurse training, old age was commonly missing from the curriculum.⁵⁵ For mental hospital nursing, an enlightened textbook by Annie Altschul (a psychiatric and general trained nurse, later professor of nursing in Edinburgh⁵⁶) aimed to remedy this. For example, she taught about how to support the patients' relatives and to encourage older, mentally unwell patients to lead fulfilling lives either within the hospital environment or aiming for discharge. Altschul's chapter on 'habit training' optimistically tackled the rehabilitation of demented patients who had lost skills due to being nursed in bed. She warned that nurses must 'never ... allow patients to deteriorate to the degree to which they did in the past'.⁵⁷

Little information is available directly from patients about their experiences. However, a letter from one contributes to the argument on the appropriateness and adequacy of care. Mr Cohen, a grandfather, was living in an institution (the specific nature of which has been elusive⁵⁸) in Surrey, over 30 miles from his east London home. He wrote to a friend in 1953:

I am here in a Place. I don't like it and the food is very bad. If you have a few £ you can buy some. And for this I worked all my life! ...

You mustn't think I want something of you, but it is a bit easier if I can speak it ...

Please excuse my bad writing but it is the best I could do.⁵⁹

Mr Cohen was distressed by his care and the environment. It was unclear why he was in an institution. His writing did not suggest dementia of a degree which required institutionalisation. Nor did he appear to be physically unwell, as the recipient of the letter, who visited him there, recollected. One cannot

⁵⁴ RMPA, 'Shortage of mental nurses' (1954) ix (TNA, MH 55/2585)

⁵⁵ Doreen Norton, 'The place of geriatric nursing in training' *Nursing Times*, 6.7.1956, 621-624

⁵⁶ Phil Barker, 'Annie Altschul: Progressive champion of psychiatric nursing' *Guardian*, 8.1.2002 <http://www.guardian.co.uk/society/2002/jan/08/mentalhealth> accessed 16.3.2013

⁵⁷ Annie Altschul, *Aids to Psychiatric Nursing* (London: Baillière, Tindall and Cox, 1957) 131-150, 145

⁵⁸ Mark Swan, Woodcote Millennium Green Trust, e-mail, Dec 2011

⁵⁹ Ida Lawrence, was the recipient and has the original (2011).

generalise from a single letter, although it reinforced the importance of creating possibilities for discharge and improving the institution's food and environment to alleviate distress.

Ward environments were often inadequate, but accommodation in many domestic dwellings, especially in urban areas and despite some overall improvements, might also be impoverished. For example, doctors visiting patients in Birmingham in 1949 described some of their homes as 'dark, infested slums'.⁶⁰ A survey in Glasgow, where housing was particularly bad, indicated that 'in spite of housing difficulties, almost all the old people we met had no desire to make a change and any suggestions to this end were usually met with hostility'.⁶¹ For older people, institutions were still perceived with the stigma of workhouses and their own homes were more than buildings. Their homes contained personal possessions and memories, linking to their identity and a sense of security, self-esteem and perceived roles in the family and community.⁶² Long-term hospital admission could psychologically deprive patients of these assets. However, the wishes of older people were often not acknowledged. Observations in the 1950s reinforced the need, already identified, for example, by Post, Rowntree, Sheldon, Lewis and Goldschmidt,⁶³ for adequate community support to maintain people as independently as possible in their own homes for as long as possible.

Cook, Dax and Maclay's study

In 1952, Leslie Cook, Eric Dax and Walter Maclay reported their analysis of hospital admission data for people over 65. Cook and Dax were experienced mental hospital psychiatrists and Maclay was a senior commissioner on the Board of Control who had a reputation for his enlightened viewpoint.⁶⁴ Their

⁶⁰ A Thomson, 'Discussion on the problems of old age' *PRSM* (1950) 43: 929-933 930-931

⁶¹ W Thomson, 'The elderly who live alone' *Medical Press* (1959) 242: 477-480 477

⁶² Duncan Macmillan, 'Preventive geriatrics' *Lancet* (1960) ii: 1439-1441 1439

⁶³ Post, 'Some problems' 561; Rowntree, *Old People*, 47; Sheldon, *Social Medicine*, 197; Lewis and Goldschmidt, 'Social causes'

⁶⁴ Anon. 'Walter Maclay' *BMHG* (1961) 4: 1: 30-34 31-32

study, triggered by concern at the number of older people in mental hospitals,⁶⁵ incorporated national statistics and local data from six hospitals. It was thorough, extensive and dedicated entirely to older people and thus it is appropriate to highlight its findings and the issues it raises.

Admission of older people to mental hospitals was, they concluded, influenced by social factors.⁶⁶ Some of their explanations were speculative rather than based on sociological evidence. For example, they alleged a decline in family obligations,⁶⁷ although other doctors reported that families were ‘unreasonably willing’ to provide care at home.⁶⁸ The latter view would be supported by Thane’s (2010) study indicating that in the 1950s there was no less family cohesiveness than in other generations.⁶⁹ The vital role of the family and the stresses on it associated with caring for a confused elderly relative was emphasised by Glasgow geriatrician William Ferguson Anderson (1914-2001, knighted 1974).⁷⁰ He observed that a sudden change in the level of confusion in an older person ‘nearly always precipitates a crisis in the patient’s family’.⁷¹ Lack of appropriate social support and professional advice left families without emotional reserve to cope with additional stress, for example, if they became overwhelmed due to a change in their own health or social circumstances, or with the onset or worsening of disturbed behaviours, memory loss, physical debility or other physical symptoms such as incontinence, in the person they cared for. ‘Domestic stress’ was the principal reason for seeking hospital admission in 120 of 900 domiciliary assessments undertaken by John DeLargy, an east London geriatrician.⁷² By comparison with geriatric medicine⁷³ (albeit

⁶⁵ Cook, ‘Geriatric problem’ 377

⁶⁶ *Ibid.* 377

⁶⁷ *Ibid.* 378

⁶⁸ CP Lowther, James Williamson, ‘Old people and their relatives’ *Lancet* (1966) ii: 1459-1460 1460

⁶⁹ Pat Thane, *Happy Families? History and Family Policy* (London: British Academy, 2010) 60-64; Thane, *Old Age*, 407-420

⁷⁰ John Brocklehurst, ‘Anderson, Sir (William) Ferguson (1914-2001)’, *ODNB*, OUP, 2008 <http://www.oxforddnb.com/view/article/89563> accessed 22.6.2010

⁷¹ Anderson, ‘Sick old people’ 343

⁷² John DeLargy, ‘Six weeks in; six weeks out’ *Lancet* (1957) i: 418-419 418

⁷³ Eric Brooke, ‘Care of the old in their homes’ *Lancet* (1949) i: 462

not yet widespread), there was no mechanism for specialist psychogeriatric domiciliary assessment and intervention. Some admissions could have been avoided by developing community care, as recommended by Amulree⁷⁴ and strongly supported by the welfare campaigning organisation, the NCCOP.⁷⁵ Similar concerns about social triggers precipitating old age mental hospital admission were raised in the USA⁷⁶ and highlighted by WHO.⁷⁷

Cook and his colleagues proposed supporting older patients and families in the community, although their conclusions did not extend to the changes needed in the infrastructure to achieve this as the 'Worthing experiment' subsequently did.⁷⁸ They were pleased that 40% of their patient group were discharged, but were also fearful of the impact of so many older people remaining in hospital. This was reflected in their final proposal:

But we must be practical and temper our remedies to the gravity of the situation. It is more economical ... to treat – say – 60 patients in two wards, than the same number in three wards. We are forced ... to overcrowd in the mental hospitals, and senile patients have proved to be the patients least affected by this; ... and owing to their interests being so much narrower and their movements more limited, their conduct and comfort are relatively little affected.⁷⁹

Cook *et al*'s statement implying that narrowing of interests was inevitable in their 'senile patients' was questionable. Alternative explanations, which were not expressed, might have included undiagnosed depressive illness or a consequence of living in an inadequate institutional environment. However, assuming this to be inevitable conveniently implied that ward improvements were unnecessary. Their stance reiterated the perceived impossibility of the situation, emphasising reducing rather than increasing or improving care. They

⁷⁴ Lord Amulree, 'The formation of a geriatric service' (1953) (BGSA, Amulree papers)

⁷⁵ Webster, 'The elderly' 169

⁷⁶ Lawrence Kolb, 'The mental hospitalisation of the aged: is it being overdone?' *American Journal of Psychiatry* (1956) 112: 627-635

⁷⁷ WHO, *Problems of Aging*, 36, 46, 49

⁷⁸ Carse, 'District' 40

⁷⁹ Cook, 'Geriatric problem' 382

stated that they did not advocate a lower standard of care for older people,⁸⁰ although it is impossible to see how this proposal could otherwise be interpreted.

Belief within the medical profession in the 1950s that senility was ‘the natural degeneration common to all persons’ and ‘the form of mental disease peculiar to this period of life’,⁸¹ reinforced the acceptability of passive and custodial care for mental illness in old age. Donald Johnson, a medically qualified Conservative MP with an interest in mental health, emphasised that custodial care was adequate by describing day hospitals, in a caring and thoughtful manner, as places where older people ‘can be parked for two or three days a week’.⁸² A *BMJ* leader, ‘Human warehouses’, was critical of the deplorable accommodation provided in the NHS for older people.⁸³ Mental hospitals provided much of this relatively cheap ‘warehouse’ accommodation. Sometimes welfare authorities were apprehensive about accepting older people from mental hospitals,⁸⁴ adding to hospital overcrowding. Fitting more people into mental hospitals was economical. In a House of Commons debate in 1954 it was estimated to cost £20 a week to keep a patient in a teaching hospital and £5 a week in a mental hospital, although precise comparisons were difficult because of technological input and higher rates of acute physical illness in the former. The low cost of mental hospitals was attributed to economies of scale, the low turnover of patients, less complex dietary requirements and patients undertaking domestic chores and food preparation.⁸⁵ Although the difference in cost raised the possibility of under-nourishment and detrimental under-spending in the mental hospitals, it was not challenged by the House.

⁸⁰ *Ibid.* 382

⁸¹ Bristol LMC, *Chronic Sick*, 33

⁸² Donald Johnson, ‘Chronic Sick and Elderly (Services)’ HC Deb 29.11.1957 *Hansard* Vol. 578 cc1443-525 1455 http://hansard.millbanksystems.com/commons/1957/nov/29/chronic-sick-and-elderly-services#S5CV0578P0_19571129_HOC_14 accessed 6.12.2011

⁸³ Anon. ‘Human warehouses’ *BMJ* (1961) ii: 100

⁸⁴ Boucher Report, 46

⁸⁵ Patricia Hornsby-Smith, ‘Mentally Sick (Care and Accommodation)’ HC Deb 19.2.1954 *Hansard* Vol. 523 cc2293-379 2378 http://hansard.millbanksystems.com/commons/1954/feb/19/mentally-sick-care-and-accommodation#S5CV0523P0_19540219_HOC_39 accessed 20.5.2010

Another important aspect of Cook *et al*'s research concerned death rates. Mental illness alone is hardly ever acutely fatal. In the six weeks following the admission of people over 65 to mental hospital, 20% died, 24 times the rate of the general population of the same age.⁸⁶ Similar high death rates shortly after admission had been observed for decades.⁸⁷ GPs were aware of this: 'The noisy, restless, agitated old person will often die if moved to a mental hospital'.⁸⁸ It is possible that high death rates were associated with sedation for disturbed behaviour.⁸⁹ However, more often, death probably resulted from an underlying physical illness causing delirium, a clinical scenario common in older people and understood at the time.⁹⁰ The observation of similar death rates in a study of older people likely to be physically unwell admitted to Amulree's wards at St. Pancras supports this hypothesis,⁹¹ although without information about clinical diagnoses, detailed comparisons cannot be made. The death rates challenged the suitability of admitting older disturbed people directly to mental hospitals, but there was little change in practice.

Cook *et al* found, that within two years of admission, about 40% died (48% men, 35% women), 40% were discharged, and 20% remained in hospital.⁹² In another study of 265 male patients admitted in 1953 (age range unstated, but those over 40 were labelled 'older', suggesting, overall, a below-65 group), 4% died, 87% were discharged, and 9% remained as in-patients after two years.⁹³ The end points of both studies, being in hospital, out of hospital or dead, were sufficiently robust to be comparable. The contrasts in outcome were disturbing, even if degenerative disorders and vulnerability to acute illnesses due to physical frailty in Cook *et al*'s group accounted for some of the differences. For Cook *et al*'s patients who survived the initial six weeks, discharge was

⁸⁶ Cook, 'Geriatric problem' 379, 380

⁸⁷ Hamilton Marr, *Annual Report: Barony Parochial Asylum at Woodilee, Dunbartonshire 1901-2* (NHS Greater Glasgow Archives, HB30/2/12A 19)

⁸⁸ Stephen Taylor, *Good General Practice* (London: OUP, 1954) 414

⁸⁹ Garry Blessed, letter, 11.6.2013

⁹⁰ JC Batt, 'Confusional mental states' *Medical Press* (1949) 222: 15-18 15

⁹¹ Lord Amulree, 'Modern hospital treatment and the pensioner' *Lancet* (1955) ii: 571-575

⁹² Cook, 'Geriatric problem' 379

⁹³ J Bickford, 'The forgotten patient. ii. One solution' *Lancet* (1955) ii: 969-971 971

most likely in the subsequent 4½ months, but additional personal details which might have shed light on this, such as age distribution and marital status,⁹⁴ were not given. Reasons associated with low rates of discharge after six months may have included frailty and chronic illness, but institutionalisation, lack of treatment and rehabilitation, or the patient's previous accommodation being unavailable due to assumptions that admission would be permanent⁹⁵ probably also contributed.

Robinson and other pioneers

One psychiatrist who set out to improve the wellbeing of mentally ill older people was Ronald (Sam) Robinson at Crichton Royal Hospital in Dumfries, Scotland. Robinson's work warrants inclusion since it influenced mental health services for older people in the rest of Britain, through written reports,⁹⁶ the Crichton Royal Behaviour Rating Scale (still used in 2009),⁹⁷ visits by colleagues from England,⁹⁸ and his leadership as chairman of the 'Section' for the Psychiatry of Old Age at the Royal College of Psychiatrists (1978-81).⁹⁹

Crichton Royal continued to be a seat of psychiatric innovation, recently developed by Willy Mayer-Gross as director of clinical research (1939-55)¹⁰⁰ and an up-and-coming researcher Martin Roth (1948-50). Roth left his mark wherever he worked. He was an outstanding psychiatric researcher and professional leader. After leaving Crichton Royal, he was director of research at Graylingwell Hospital, Chichester, one of a handful of British mental hospitals with a research department.¹⁰¹ He became professor of psychiatry at

⁹⁴ Eileen Brooke, *A Cohort Study of Patients First Admitted to Mental Hospitals in 1954 and 1955* (London: HMSO, 1963) 163-164

⁹⁵ Anon. 'Hospital beds shortage. Liverpool waiting list 12,622' *Times*, 29.12.1952, 2

⁹⁶ e.g. Robinson, 'Organisation'

⁹⁷ *Ibid.*; Anoja Rajapakse, Jacqui Bussin, 'Prevalence of challenging behaviour among older in-patients: a pilot study' *Psychiatric Bulletin* (2009) 33: 277-278

⁹⁸ Klaus Bergmann, 'Witness' 10

⁹⁹ 'Witness' 2, footnote 3

¹⁰⁰ Hugh Freeman, 'Gross, William Mayer- (1889-1961)', *ODNB*, OUP, Jan 2011
<http://www.oxforddnb.com/view/article/51731> accessed 12.6.2012

¹⁰¹ Martin Roth, interviewer Margot Jefferys (BLSA, 1991)

Newcastle upon Tyne in 1956, then at Cambridge in 1977. He was the first president of the Royal College of Psychiatrists and was knighted in 1972.¹⁰² His research and his legacy to psychogeriatrics will be referred to elsewhere in this thesis. Robinson attributed the interest at Crichton Royal, in accurate diagnosis and treatment of older mentally ill people, to Mayer-Gross and Roth.¹⁰³

Robinson's was not the first experimental old age scheme at Crichton Royal. In the early 1950s, the medical superintendent decided that all patients regardless of age should be admitted via acute admission wards, rather than directly to back wards, in order to improve outcomes. However, the acute admission wards became overfull with older people. It was also clear that mixing older, frail, restless and confused people with acutely disturbed younger people was not conducive to safety or wellbeing.¹⁰⁴ Despite the difficulties created by the new scheme, the leadership at Crichton Royal was receptive to other suggestions for older people.

Robinson, while a junior doctor, attended an international gerontology congress in London where he was inspired by an American psychiatrist, Raphael Ginzberg.¹⁰⁵ Ginzberg emphasised a model of care centred on respect, understanding the emotional needs of mentally unwell older people and manipulating the environment to ensure calm. Central tenets of Ginzberg's 'attitude therapy' included 'an atmosphere of acceptance', trying to understand the meaning of abnormal behaviours and avoiding patronising platitudes 'that neither he [the patient] nor anyone else believes'.¹⁰⁶

¹⁰² Michael Gelder, 'Roth, Sir Martin (1917-2006)', *ODNB*, OUP, Jan 2010 <http://www.oxforddnb.com/view/article/97473> accessed 12.6.2012; Caroline Richmond, 'Sir Martin Roth' *BMJ* (2006) 333: 1175

¹⁰³ Robinson, 'Witness' 10

¹⁰⁴ *Ibid.* 9

¹⁰⁵ *Ibid.* 9

¹⁰⁶ Raphael Ginzberg, 'Psychiatric and psychological techniques in the treatment and management of elderly psychotics' 457-462. In: International Association of Gerontology (IAG) *Third Congress: old age in the modern world* (Edinburgh: Livingstone, 1955) 461

Adopting an American clinical approach was problematic. Usually American psychiatrists learned from the relatively liberal attitude of the UK mental hospital system, such as open door policies and the voluntary status of patients.¹⁰⁷ The biological approach of UK psychiatrists contrasted with the psychodynamic theories influencing American psychiatry. In the USA, psychiatrists attributed brain disorders in old age to psychological factors and poor adaptation to life stresses, while in the UK the same disorders were attributed to biological processes. The American hypothesis was challenged by British psychiatrists, including, in Jesse Ballenger's view, a 'sustained and rigorous attack on the psychodynamic model' by Roth.¹⁰⁸ Ginzberg's psycho-social interventions ameliorated symptoms, probably because they helped the *consequences* of distorted thinking rather than the causes. Robinson grasped Ginzberg's humane method for improving dementia care alongside principles of geriatric treatment and rehabilitation already practiced in the UK.

Fortunately, the research milieu of Crichton Royal permitted Robinson to trial his approach – a specialised old age unit with its own admission ward. A less progressive establishment might have shunned controversial suggestions from a junior doctor or a recently appointed consultant on grounds of naivety or inexperience. If Ginzberg influenced the founding of the Crichton Royal old age service, he also influenced the development of the specialty in the rest of the UK. An American influence on the foundations of the specialty is not usually acknowledged.

Robinson later reflected:

The Board of Management gave me two weeks study leave in order to view the field, psychiatric and geriatric. I found several psychiatrists with a special interest in the elderly ... nowhere did I find the sort of comprehensive service which I had in mind.¹⁰⁹

¹⁰⁷ Jones, *Asylums and After*, 153-154

¹⁰⁸ Ballenger, *Self, Senility*, 52-55, 53

¹⁰⁹ Robinson, 'Witness' 10

Inspiration, ingenuity and creativity were at the heart of Robinson's scheme. There was some opposition by the consultant establishment, for example that 'it would be a luxury service which would dilute our already stretched manpower'.¹¹⁰

The innovative and unique unit opened in 1958 for all new referrals over the age of 65, for a trial period of one year. Out-patient and domiciliary assessments were offered. There were 282 beds organised into admission, rehabilitation, long-stay, and infirmary wards. Therapeutic interventions included the range of treatments available to younger people.¹¹¹ The discharge rate was 60%, almost all patients with functional disorders and one-third of those with organic disorders,¹¹² but data on death rates which compare meaningfully with other studies, e.g. of Cook *et al*, have not been identified.

Similar to Post's report on his work in Edinburgh in 1944, Robinson's developments fell geographically outside the radar of the Ministry of Health. Descriptions of Robinson's service were published in conference proceedings with a small distribution rather than in prestigious general medical journals.¹¹³ His unique and important work received little direct acknowledgment.

Other provincial schemes

Much service related information in the late 1950s was documented in a national survey of day hospitals by James Farndale, a barrister and deputy house governor (today, equivalent to deputy chief executive) at the Bethlem-Maudsley.¹¹⁴ At that time, day hospitals were innovative, so places where they existed were likely to have generally taken more creative approaches to mental

¹¹⁰ *Ibid.* 10

¹¹¹ Ronald Sneddon, 'Psychiatric geriatric assessment unit at Crichton Royal Hospital' *Nursing Mirror*, 7.4.1967, x-xv

¹¹² Robinson, 'Organisation' 197, 199

¹¹³ Ronald (Sam) Robinson, 'The practice of a psychiatric geriatric unit' 1-19. In: *Aspects of Geriatric Psychiatry, Haematology, Nutrition and Cancer in Old Age* (IAG, September 1961) ed. E Woodford-Williams, AN Exton-Smith (Basle: Karger, 1962)

¹¹⁴ James Farndale, *The Day Hospital Movement in Great Britain* (Oxford: Pergamon Press, 1961)

illness, possibly including services for older people. Farndale stated the age range of people attending each service he described, identifying some pockets of psychogeriatric activity, but overall suggesting relatively little provision for older people. Nevertheless, there were some new schemes. In Nottingham, mental hospital medical superintendent, Duncan Macmillan, developed community support, short term assessment, long-stay care and a day hospital for older people.¹¹⁵ Macmillan's work resembled Robinson's comprehensive service, but the published data relating to his service in the 1950s do not allow detailed comparisons.¹¹⁶ Sheffield had a geriatric unit in a psychiatric hospital by 1953; treatments included ECT and social interventions, but otherwise care was typically custodial.¹¹⁷ In Oldham, a day hospital and a unit for 'senile demented' ¹¹⁸ were established by Arthur Pool, despite his unfavourable comments on specific mental health services for older people at the RMPA conference in 1945.¹¹⁹ Psychiatric day hospitals elsewhere, such as in Birmingham, Bolton, Burnley, Croydon and Hull accepted older patients.¹²⁰

Developments at the Bethlem-Maudsley

Clinical challenges

Developments at the Bethlem-Maudsley require exploration because of its status as a postgraduate teaching hospital. Many budding psychiatrists trained there and some subsequently established psychiatric units in undergraduate teaching hospitals. Detailed minutes of the Bethlem-Maudsley Medical Committee and the General Purposes Sub-committee reveal attitudes towards the care of older people expressed by senior psychiatrists who were likely to have transmitted the same messages to their juniors, the future leaders in the field.

¹¹⁵ Macmillan, 'Preventive geriatrics'; Farndale, *Day Hospital*, 343-347

¹¹⁶ Macmillan, 'Preventive geriatrics'

¹¹⁷ GI Tewfik, 'A review of the psychotic elderly resident in a mental hospital' *JMS* (1956) 102: 247-263

¹¹⁸ Farndale, *Day Hospital*, 301-303

¹¹⁹ Pool, In: 'General discussion'

¹²⁰ Farndale, *Day Hospital*, 208, 216, 230, 243, 264

Clinically, the Bethlem-Maudsley was different from most mental hospitals. It was not constrained by catchment area obligations. There were no long-stay wards; patients who did not recover were transferred to other mental hospitals. For older people, unlike in other mental hospitals, making a specific diagnosis and providing active treatment was standard practice. Patients were only admitted to the Geriatric Unit if they had a functional mental illness which might respond to treatment. In 1952, of 133 admissions to the Unit, 113 (85%) returned home or to the care of friends. One year later, 45 were symptom-free and a further 35 were symptomatic but out of hospital.¹²¹ These results cannot be compared with other studies because of the rigid admission criteria. With no model to follow, or expectations of positive outcome, Post's success surprised him and his ambivalence towards working with older people changed to optimism.¹²² The hospital began to take pride in the Geriatric Unit's achievements. In 1955 it was included in a tour of the hospital by their patron, the Duchess of Kent.¹²³

In 1950, less than a year after the Geriatric Unit opened, Post wanted to extend treatment and options for follow-up. The 'Gresham Club' was created for discharged patients.¹²⁴ It met one afternoon a week in a community hall in Camberwell Green, away from the hospital and closer to many patients' homes, and offered activities and emotional support. It was popular among patients, and for staff it reinforced what could be achieved by treating and rehabilitating older people.¹²⁵ Developing the club indicated Post's desire to extend the range of services provided.

Broadening services to people with dementia remained problematic. Post requested a long-stay unit as part of proposed redevelopments. He acknowledged that a 'chronic department' differed from Maudsley's

¹²¹ Post, 'Geriatric Unit' 271

¹²² Post (BLSA)

¹²³ Anon. 'Visit of her Royal Highness the Duchess of Kent to Bethlem on 21st July 1955' *BMHG* (1955) 2: 2: 45-51

¹²⁴ Felix Post to Bethlem-Maudsley Medical Committee, letter, 15.7.1950, MCD69/50 (BMHA)

¹²⁵ Catherine Colwell, 'Out for the day' *BMHG* (1954)1: 182-183 183

specifications for treating acute psychiatric illness, but ‘times have changed’, long-stay patients were important for research and for training staff to work in mental hospitals.¹²⁶ Post’s suggestions were rebuffed by the General Purposes Sub-committee; he could do as he wished with his designated beds but no more resources were available.¹²⁷ His views on the importance of degenerative disorders appeared almost incomprehensible to colleagues prioritizing younger people. There was strong resistance by senior medical staff to having any long-stay patients at the Bethlem-Maudsley. Like other teaching hospitals,¹²⁸ acute treatment was prioritised and chronic conditions were largely ignored. Post later wrote that dementias were neglected ‘on account of admission restrictions before the hospital abandoned its ivory tower’.¹²⁹

Various reports on old age¹³⁰ were presented to the Medical Committee. They were analysed in a report by Carlos Blacker,¹³¹ who was noted previously to prioritise the needs of younger people.¹³² His leadership of this project seemed unlikely to ensure a fair hearing. Lewis was among those consulted for the report. Post was not, despite his role with older people.¹³³ Reasons were not given for the choice of people consulted. It is conceivable, but unlikely, that Post was asked but refused to contribute. More likely, an old age psychiatrist’s opinion was not considered relevant, implying that the really important clinicians were those working with younger people. This mirrored the initial exclusion of geriatricians from a BMA committee in 1954 when planning medical services for older people.¹³⁴

¹²⁶ Felix Post to Bethlem-Maudsley Medical Committee, letter, 13.7.1954, GPD24/54, MCD56/54 (BMHA)

¹²⁷ Bethlem-Maudsley General Purposes Sub-committee, minutes, 19.10.1954, GPD27/54, MCD63/54, GPM63 (BMHA)

¹²⁸ BMA General Medical Services Committee, ‘Report of a section of the London LMC on the problem of the aged and infirm sick, and ancillary matters’ 18.2.1954, 3 (BMAA)

¹²⁹ Post, ‘In the beginning’ 16

¹³⁰ e.g. National Old People’s Welfare Council, *Mental Frailty*

¹³¹ Carlos Blacker, ‘Mentally infirm people over 65: need for better means of support and disposal’. Bethlem-Maudsley Medical Committee, 1.1.1959, MCD7/59 (BMHA)

¹³² Blacker and Gore, *Triennial Report*, 15-16

¹³³ Blacker, ‘Mentally infirm’ 21 (BMHA)

¹³⁴ BMA, Geriatrics Joint Sub-committee, agenda, 24.2.1954 (BMAA)

Despite being for local use, Blacker's report did not include local social and demographic circumstances. He advocated a more unified service for older people which would give

benefits to mental hospitals. These could expect to be relieved from pressure caused by aged and infirm people ... nearly a third of their inmates. Psychiatric teaching hospitals would benefit from the relief afforded to mental hospitals.¹³⁵

In other words, if fewer older people were admitted, this would ultimately enable the Bethlem-Maudsley to function as it wished, mainly to treat acutely unwell younger patients. Interestingly, the term 'inmates' was already regarded as derogatory,¹³⁶ and was rarely used in British psychiatric literature in the 1950s except in the context of forensic psychiatry.¹³⁷ It may have reflected Blacker's, or the Bethlem-Maudsley's, negative stance towards chronically unwell patients in mental hospitals. After completion, discussion of Blacker's report did not reappear in the Medical Committee minutes, suggesting that it did not lead to any modifications of services. A few months later, a memorandum advocated a 'Comprehensive Community Mental Health Service' for patients of all ages within a defined catchment area. It was considered by the Medical Committee, without enthusiasm,¹³⁸ but also was not discussed subsequently. It is unclear how much the powerful Professorial Unit, known to prefer 'interesting' patients from anywhere in the UK to providing a local service,¹³⁹ influenced this important proposal.

Post could not break through the Medical Committee's mindset, which perpetuated an inferior share of resources for older people. His struggles reflected the tensions between the acute intervention culture of a teaching hospital and the objectives of NHS comprehensive care. Evidence of the

¹³⁵ Blacker, 'Mentally infirm' 21 (BMHA)

¹³⁶ Committee on Care and Treatment, meeting, 16.5.1946; Marjory Warren, Eric Brooke, Lionel Cosin, 'Problem of the chronic sick' (BMAA)

¹³⁷ Word search, 'inmate' *BJPsych* 1950-1970

¹³⁸ Bethlem-Maudsley Medical Committee, minutes, 4.11.1959, MCD62/59 (BMHA)

¹³⁹ *Ibid.* 1.10.1953, MCD1/54 (BMHA)

rejection of Post's proposals does not support criticism of him by subsequent generations of psychogeriatricians for failing to develop innovative services.¹⁴⁰

Lionel Cosin, geriatricians and psychiatry

Geriatricians developed their interests in a clinical terrain virtually barren of geriatric expertise. Day hospitals, domiciliary assessment, community care, in-patient treatment, rehabilitation, research and respite care were among the activities contributing to a shared objective of improving the health of older people. In contrast to the low profile of psychogeriatrics, Cosin and Amulree put geriatric medicine on the political agenda. Cosin (Fig 6) 'was always ready to go to the top to get what he wanted: "camp on the minister's doorstep" was once his advice to a frustrated colleague'.¹⁴¹

Fig 6. Lionel Cosin: 'small in stature but big in ideas'



Source: RE Irvine, 'LZ Cosin' *BMJ* (1994) 309: 189 (Copyright: see appendix, page 344)

¹⁴⁰ Robin Jacoby, interview by author (2004)

¹⁴¹ Irvine, 'Cosin'

In 1952, Cosin established a geriatric day hospital at Cowley Road Hospital, Oxford, treating physical and psychiatric disorders. It was much visited by doctors from abroad¹⁴² but scarcely impinged on the awareness or education of Oxford medical students.¹⁴³ Cosin, and his colleague Philip Bedford, who wrote eloquently and constructively about confusion in old age,¹⁴⁴ chose, or perhaps were allowed, only to display their talents as physicians, rather than as geriatricians, when teaching students. The absence of chronic illness and old age teaching from most undergraduate medical schools and from text books meant that medical students did not learn that work with older people could be worthwhile and rewarding. With regard to textbooks, Sir John Conybeare's respected and vast *Textbook of Medicine* (1949), for example, included roughly equivalent length passages – less than one page each – on senile dementia and verrucae (warts),¹⁴⁵ and *Price's Textbook of the Practice of Medicine* in 1956 had no chapter on geriatric medicine.¹⁴⁶

Like Warren, Cosin was enthusiastic about a holistic approach to care. Cosin led a multi-disciplinary team, which actively treated older people, helped them maintain their independence and supported families to prevent long-stay hospital admission. He understood the stresses on the family of caring for confused relatives, and that, if social care broke down, long-stay admission was almost inevitable. Cosin's demonstration that his day hospital could prevent social crises and hence long term hospital admissions was sufficiently noteworthy to appear in the *Guardian*.¹⁴⁷ His scheme included 'floating' ('respite') beds to help families caring for older people suffering from chronic

¹⁴² Cosin (BLSA)

¹⁴³ Tom Arie, e-mail, Dec. 2011

¹⁴⁴ Philip Bedford, 'General medical aspects of confusional states in elderly people' *BMJ* (1959) ii: 185-188

¹⁴⁵ John Conybeare (ed.) *Textbook of Medicine* (Edinburgh: Livingstone, 1949) 764-765, 830-831

¹⁴⁶ Donald Hunter (ed.) *Price's Textbook of the Practice of Medicine* (Oxford: OUP, 1956)

¹⁴⁷ Anon. 'Helping the elderly and the confused to carry on: year's success at an Oxford Day Hospital' *Guardian*, 15.1.1954, 5

physical and mental conditions.¹⁴⁸ Schemes of day hospital plus in-patient respite care were rare, although, notably, DeLargy had a similar programme.¹⁴⁹

Cosin thought that the relationship in Oxford between geriatricians and psychiatrists was not conducive to collaboration,¹⁵⁰ although it was unclear how much hospital organisation and how much individual personalities, including Cosin's, contributed to that. Cosin was not always popular, and sometimes did not see eye-to-eye even with geriatrician colleagues.¹⁵¹ Cosin objected to the psychiatrists at Littlemore, the Oxford mental hospital, complaining that he did not take enough of their older patients when he calculated that his day unit supported five times more confused patients living at home than in all the wards at Littlemore.¹⁵² Whether Cosin's approach to psychiatric conditions was his ideal or resulted from local circumstances was unclear, but he demonstrated what could be achieved.

Cosin regarded psychiatrists as clinically inept with older people:

The psychiatrists diagnosed senile dementia. Period. That's the end. *Finis* ... the function of a psychiatrist is to depart from clinical responsibility.¹⁵³

Cosin was not alone in his views; at least one other geriatrician, George Adams, working in Belfast from the outset of the NHS, remarked: 'many psychogeriatricians are not proper doctors'.¹⁵⁴ Both Cosin and Adams were recognised leaders in geriatrics, so their views had the potential for broader consequences regarding collaboration.

¹⁴⁸ Cosin (BLSA)

¹⁴⁹ Farndale, *Day Hospital*, 356-358; DeLargy, 'Six weeks'

¹⁵⁰ Cosin (BLSA)

¹⁵¹ Denham, 'Geriatric medicine' 87-88

¹⁵² Cosin (BLSA)

¹⁵³ *Ibid.*

¹⁵⁴ George Adams, interviewer Anthea Holmes (BLSA, 1991)

Geriatric medical interest and clinical methods were largely absent from mental hospitals, despite evidence of need. Denham argued that the Ministry did little to encourage geriatricians to do this work, tending to follow the geriatricians' practices and preferences.¹⁵⁵ Small numbers of geriatricians faced massive tasks in their own hospitals, let alone in mental hospitals, but, as Cosin noted at Littlemore, unenthusiastic psychiatrists did little to encourage them.

Collaborative work was also needed in general hospitals but was slow to materialise. The Ministry's recommendation in 1950, for medical and psychiatric assessment of older people in geriatric departments,¹⁵⁶ was implemented only hesitantly. In 1959, WHO recommended active treatment of delirium¹⁵⁷ but noted one of the difficulties: 'medical and psychological problems of the aged person do not arouse everyone's sympathy and interest'.¹⁵⁸ In 1960, the Ministry commented: 'One of the most urgent and complex problems is the care of mentally enfeebled old people'. It 'hoped' that more geriatric-psychiatric links would be forged.¹⁵⁹ That a problem could be described as 'urgent' and the response as 'hope' suggested that the Ministry lacked commitment to resolve it.

When Post wished to investigate clinical interventions in dementia, impossible at the Bethlem-Maudsley because of admission criteria, he collaborated with Cosin. An investigation of the effects of occupational therapy on communication and behaviour in 'persistent senile confusion' was proposed, to be undertaken in Oxford. The Bethlem-Maudsley Medical Committee grudgingly agreed to the proposal after stating that Post's research should be carried out at his own hospital.¹⁶⁰ Unfortunately, the study found little benefit

¹⁵⁵ Denham, 'Geriatric medicine' 357

¹⁵⁶ MoH, *Care of the Aged*, 1; MoH, *Treatment of the Elderly*, 1

¹⁵⁷ WHO, *Problems of Aging*, 31

¹⁵⁸ *Ibid.* 38

¹⁵⁹ MoH, *Report for the Year 1960: Part II: on the state of the public health* Cmnd. 1550 (London: HMSO, 1961) 98

¹⁶⁰ Bethlem-Maudsley Medical Committee, minutes, 6.9.1954, MCM87 (BMHA)

from the interventions.¹⁶¹ Cosin commented that ‘Post made no recommendations for psychogeriatrics’.¹⁶² That may have been because psychiatric expertise was unnecessary for the study, although it had been stipulated by the funding body.¹⁶³ For Cosin, the experience might have reinforced his rejection of psychiatrists and psychiatry.

Research

Classifying mental disorders in old age

An important forum for discussing and inspiring research into older people’s mental disorders was the Geriatric Committee of the RMPA’s Research and Clinical Section, inaugurated in February 1951.¹⁶⁴ Several distinguished psychiatrists served on the committee including Macmillan, Post, Roth and Linford Rees (president, Royal College of Psychiatrists, 1975-78).¹⁶⁵ Other committee members, whose studies have already been outlined, included Affleck, Cook, Dax, Maclay and Richter. The repetition of certain names emphasises the tiny network of people involved clinically and in research in the field and their tenacious adherence to it.

The committee was established in response to the rising numbers and proportion of older people in mental hospitals,¹⁶⁶ the BMA report (1947)¹⁶⁷ and the Ministry of Health’s circular (1950).¹⁶⁸ The Geriatric Committee agreed with the BMA’s and the Ministry’s recommendations. There was no rush for psychiatrists to take over clinical responsibility from the geriatricians for

¹⁶¹ Lionel Cosin, Margaret Mort, Felix Post, Celia Westropp, Moyra Williams, ‘Experimental treatment of persistent senile confusion’ *International Journal of Social Psychiatry* (1958) 4: 24-42 24, 41

¹⁶² Cosin (BLSA)

¹⁶³ *Ibid.*

¹⁶⁴ RMPA, Geriatric Committee of the Research and Clinical Section, minutes, 14.2.1951 (RCPsychA). ‘Sub-committee’ and ‘committee’, ‘geriatric’ and ‘geriatrics’ were used interchangeably for this group. I have used ‘Geriatric Committee’ for consistency and clarity.

¹⁶⁵ Caroline Richmond, ‘Linford Rees’ *BMJ* (2004) 329: 744

¹⁶⁶ MH-SAC, ‘Care of the Aged: remit’ (c.1949) Para 3 (TNA, MH 133/502); MoH, *On the State of the Public Health, being the Annual Report of the Chief Medical Officer for the Year 1950* Part 2. Cmnd. 8582 (London: HMSO, 1952) 137

¹⁶⁷ BMA, *Care and Treatment*

¹⁶⁸ Geriatric Committee, ‘Report’ (1951) 4 (RCPsychA); MoH, *Care of the Aged*

mentally unwell older people. The committee set clinical objectives, such as establishing close liaison with medical and other organisations treating and caring for older people.¹⁶⁹ However, the minutes subsequently do not mention these objectives, suggesting they were overtaken by the research imperative.

Probably the most significant research report on mental disorders in older people during the 1950s was Roth's system of diagnostic classification.¹⁷⁰ The minutes indicate that the Geriatric Committee inspired and encouraged his research. In May 1951 Roth agreed to prepare a report for them on the subject.¹⁷¹

Roth's study reviewed the case notes of 472 people admitted to Graylingwell Hospital in the 1930s and 1940s. His analysis of clinical history, symptoms and outcome identified five diagnostic categories: affective psychosis, late paraphrenia, acute confusion, arteriosclerotic psychosis and senile psychosis, which in modern terminology would equate with depressive (including bi-polar) illness, late onset schizophrenia, delirium, vascular dementia and Alzheimer's dementia. Each category had a different outcome, confirming that the first three were each distinct disorders and were not aetiological precursors of the last two. Despite the clarity of Roth's argument, the Committee doubted his conclusions, which contradicted time-honoured teaching. They 'felt it was important to determine whether these findings were of general application',¹⁷² and planned to survey their own hospitals. Their report to the RMPA Council in October 1957, six years after Roth proposed the research and two and a half years after his paper was published, verified that the findings were generally applicable.¹⁷³ Importantly, the RMPA acknowledged that diagnosing and classifying different disorders in old age was possible and that the previous hypothesis of a single irreversible mental disorder in old age was obsolete.

¹⁶⁹ Geriatric Committee, minutes, 14.2.1951, 3 (RCPsychA)

¹⁷⁰ Roth, 'Natural history'

¹⁷¹ Geriatric Committee, 10.5.1951, 4 (RCPsychA)

¹⁷² Geriatric Committee, 'Report to Council on the course and outcome of mental disorders in old age' (1957) 1 (RCPsychA)

¹⁷³ *Ibid.* 10

Perhaps believing their work was done, the Geriatric Committee disbanded in 1959.¹⁷⁴

Roth's methodology for classifying mental illnesses in older people resembled Kraepelin's for younger people 50 years earlier.¹⁷⁵ He, like Kraepelin, was probably not entirely original in his thinking: Kraepelin's work was probably inspired by Karl Kahlbaum¹⁷⁶ and Roth's by Mayer-Gross.¹⁷⁷ Roth's source of inspiration in no way undermines the importance of his research. Rather, it emphasises the slow moving nature and difficulties of objectively researching the fundamental phenomenology of psychiatry, research which is largely based on intangible psychopathological philosophical concepts rather than visible physical pathology.

Research outcomes which challenge entrenched attitudes and practices are accepted only gradually. Adoption of Roth's classification system by psychiatrists was predictably slow. By contrast, technological innovations perceived as scientific advances were more readily accepted, implemented and evaluated, and were newsworthy and widely valued. In medical practice, financial, medical or ethical controversy might impinge on the implementation of new, high-tech interventions, such as oral contraceptives, renal dialysis or organ transplantation, but not to the degree which it impeded the introduction of low-tech psychological and social techniques. Even within psychiatry, the slow pace of implementing social and psychological interventions contrasted with the speedier adoption of pharmacological and physical treatments,¹⁷⁸ despite the discrediting of some physical treatments during the 1950s¹⁷⁹ which might have made psychiatrists wary of clinical change. The slow adoption of non-technological developments corroborates historian Paul Bridgen's analysis

¹⁷⁴ Geriatric Committee, agenda, 11.2.1959 (RCPsychA)

¹⁷⁵ Kraepelin, *Clinical Psychiatry*, 115-120

¹⁷⁶ Peter Braünig, Stephanie Krüger, 'Karl Ludwig Kahlbaum MD (1828-1899)' *American Journal of Psychiatry* (1999) 156: 989

¹⁷⁷ Robinson, 'Witness' 41

¹⁷⁸ Shorter, *History of Psychiatry*, 190-238

¹⁷⁹ Brian Ackner, Arthur Harris, A Oldham, 'Insulin treatment of schizophrenia; a controlled study' *Lancet* (1957) i: 607-611

that the early NHS was disappointing from the old age perspective. He argued that, despite relative improvements in provision in acute hospitals, ideas about the treatment of older people were slow to be integrated.¹⁸⁰ Changing bed bound, incontinent, confused, institutionalised older patients into mobile, continent and relatively independent individuals in their own homes was no less remarkable than technological innovations, but those achievements were not newsworthy, nor given equal priority or support.

Other clinical research

In the 1950s, psychiatric research studies were mainly mental hospital based. Roth collaborated with psychologist Barbara Hopkins to investigate the psychological test performance of patients with various psychiatric diagnoses, which substantiated his hypothesis of a range of disorders occurring in old age, and, importantly, pointed to ways of differentiating between them.¹⁸¹ Post also collaborated across the disciplines to help clarify the organic-functional diagnostic interface.¹⁸² Accurate diagnosis was essential, not just to underpin effective treatment, but to provide foundations for epidemiological studies to identify the prevalence of disorders in the community and to plan for population needs. There was a dearth of epidemiological studies about mental disorders in old age compared with similar studies about physical disorders.¹⁸³ The absence of precise psychiatric diagnostic criteria probably hampered research.

New research presented at gerontology conferences attracted participants from many countries and many disciplines (Fig 7). In 1950, the International Association of Gerontology was founded in London. Their third congress in 1954 included research presentations by Roth, Post, Robinson and other UK

¹⁸⁰ Paul Bridgen, 'Hospitals, geriatric medicine, and long-term care of elderly people 1946-76' *Social History of Medicine* (2001) 14: 507-523 507-508

¹⁸¹ e.g. Martin Roth, Barbara Hopkins, 'Psychological test performance in patients over 60. i. Senile psychosis and the affective disorders of old age' *JMS* (1953) 99: 439-450

¹⁸² e.g. J Inglis, Catherine Colwell, Felix Post, 'An evaluation of the predictive power of a test known to differentiate between elderly "functional" and "organic" psychiatric patients' *JMS* (1960) 106: 1486-1492

¹⁸³ e.g. W Hobson, J Pemberton, 'The health of the elderly at home' *BMJ* (1956) i: 587-593

researchers such as David Kay, who had been a junior doctor working with Post at the Bethlem-Maudsley¹⁸⁴ before moving to Newcastle upon Tyne to work with Roth. Nine of the seventeen presentations in the ‘neuropsychiatry’ section were from the UK. The others were from the USA, France, Finland, and Austria.¹⁸⁵ Although selection bias can not be ruled out, since the conference took place in London and the neuropsychiatry section was organised by Post on the invitation of Warren,¹⁸⁶ the disproportionate contribution by UK psychiatrists was notable.

Fig 7. Felix and Betty Post at the International Association of Gerontology Congress, Italy, 1957



Source: Julian Post (FP)

The view from general practice

GPs held the keys to community medical and nursing resources and to hospital admission and were crucial to the welfare of older people. However, mental disorders typically occurring in old age risked being overlooked clinically and

¹⁸⁴ Bethlem-Maudsley Medical Committee, minutes, 19.8.1949, memorandum by house governor on staffing, MCD56/49 (BMHA)

¹⁸⁵ IAG, *Modern World*, 393-394

¹⁸⁶ Felix Post, ‘Marjory Warren Memorial Lecture, February 1979’, manuscript R16068 (Institute of Psychiatry)

omitted from research.¹⁸⁷ Patients and their families might not regard the symptoms as matters for the GP. GPs might not recognise the disorders, or consider them worth recognising in the early stages, or might attribute them to ageing rather than illness, thus categorising them as less relevant to their work.¹⁸⁸ If people exhibiting difficult behaviours were admitted to long-stay wards, they would disappear from their GP's list.

Stephen Taylor, a physician working with the NPHT, investigated thirty outstanding general practices, aiming to depict practice worthy of adoption elsewhere. He noted a diversity of views about older people. Some GPs thought that, with time and patience, working with them could be rewarding. Other GPs viewed them as 'difficult, and even unpleasant ... often inarticulate, hard to get to know, and slow to respond'.¹⁸⁹ One husband and wife GP team, Cuthbert and Beatrice Watts, wrote gloomily that 'senile demensia' (sic) is common in the 'last decade of life', 'Nothing can be done for these unfortunate people'¹⁹⁰ and 'The aged can be most difficult and trying'.¹⁹¹ They appropriately commented that depressive illness was common in old age.¹⁹²

Although there was some awareness within primary care of the need to support families, some GPs thought it best to advise the family that providing care 'can only have an adverse effect on their own lives, without benefiting the patient's in the slightest', and since 'no additional help can be sufficient to make it bearable', admission to long-stay care was preferable.¹⁹³ Such comments suggested that some GPs lacked motivation to attempt to improve community psychogeriatric care, or perhaps lacked understanding that it might be possible.

¹⁸⁷ Taylor, *Good General Practice*, 416-420; John Fry, 'A year of general practice: a study in morbidity' *BMJ* (1952) ii: 249-252

¹⁸⁸ Webster, 'The elderly' 181

¹⁸⁹ Taylor, *Good General Practice*, 413

¹⁹⁰ Cuthbert Watts, Beatrice Watts, *Psychiatry in General Practice* (London: J and A Churchill, 1952) 140

¹⁹¹ *Ibid.* 145

¹⁹² *Ibid.* 145

¹⁹³ Ronald Gibson, 'The care of the elderly in general practice' *Research Newsletter* (1957) 4: 99-114 111

It is difficult to be sure whether those attitudes were widespread, but they demonstrate at least some opposition to the objectives of the geriatricians and interested psychiatrists and the depth of the pessimism which needed to be overcome.

Webster commented that GPs perpetuated adverse assumptions of the irreversibility of the problems of old age.¹⁹⁴ However, some, such as John Anderson, a GP in Edinburgh, wrote positively about treatment. One wonders if his constructive attitude stemmed from experience with the recently established local geriatric medicine department.¹⁹⁵ He emphasised that active treatment for acute-on-chronic illness and good management of chronic disorders, such as providing spectacles, hearing aids and chiropody, could improve quality of life.¹⁹⁶ Unfortunately, despite mentioning mental wellbeing, he did not discuss severe and disabling mental disorders in old age.

None of the primary care reports suggested enthusiasm about interventions for psychiatric disorders to improve quality of life of older people. If GPs were unaware of the possibilities, despite articles in general medical journals,¹⁹⁷ it was unlikely that older patients would be referred to psychiatrists for assessment and advice. Arthur Harris, an ally of Post at the Bethlem-Maudsley, commented that GPs

still tend to take an unwarrantably pessimistic view of mental illness in the elderly ... No practitioner need ever feel apologetic about asking a psychiatrist to see an old person.¹⁹⁸

¹⁹⁴ Webster, 'The elderly' 181

¹⁹⁵ James Williamson, 'Witness' 21-22

¹⁹⁶ John Anderson, 'The care of the elderly in general practice' *Research Newsletter* (1957) 4: 193-211 200-206

¹⁹⁷ e.g. Felix Post, 'Emergencies in general practice: senile confusion' *BMJ* (1955) ii: 315-317

¹⁹⁸ Arthur Harris, 'What can the general practitioner expect of the psychiatrist?' *Medical Press* (1953) 229: 297-300 299

A quartet of reports

Reports from several government appointed committees indicated lack of interest or resolve about providing for older people's health needs. Four major reports with direct bearing on health and welfare provision for older people were published in the 1950s. Their main themes were the economics of supporting older people,¹⁹⁹ mental health provision for all ages,²⁰⁰ the cost of the health service²⁰¹ and facilities for older people's physical health care.²⁰²

Committee on the Economic and Financial Problems of the Provision for Old Age (Phillips Report) 1954

The far from neutral title of Sir Thomas Phillips' committee may have reflected its attitude towards older people. The report hardly mentioned health care. However, it touched on the increasing number of admissions of older people to mental hospitals, and commented wishfully that 'their discharge rate will also increase in the near future', an assertion attributed to a 1953 report by the Board of Control.²⁰³ There was no evidence of that trend beginning, but believing it unquestioningly seemed shrewd if the committee aimed to justify reducing expenditure on hospitals.²⁰⁴

Phillips' report referred to Rowntree,²⁰⁵ but not to Sheldon's study or the BMA's report (1947), paying little attention to earlier geriatric recommendations. It made vague proposals without specific goals, emphasising the need for more evidence because 'it is difficult to obtain a clear picture of the sort of services old people will need, or the scale on which they should be provided'.²⁰⁶ More information might have been useful, but much was already known about the demographic changes and the needs of older

¹⁹⁹ Phillips Report

²⁰⁰ Percy Report

²⁰¹ MoH, *Report of the Committee of Enquiry into the Cost of the National Health Service* Cmd. 9663 (Guillebaud Report) (London: HMSO, 1956)

²⁰² Boucher Report

²⁰³ Phillips Report, 9

²⁰⁴ *Ibid.* 74

²⁰⁵ *Ibid.* 71

²⁰⁶ *Ibid.* 83

people and there was a back-log of unimplemented recommendations. Stating the need for more information avoided the need for government action.

Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Report) 1957

The report of the Royal Commission laid the foundations for the MHA 1959. Mental health legislation largely focuses on patients who, by reason of their mental disorder, might put themselves or others at risk and who refuse psychiatric assessment and treatment when it is clinically indicated.

There was no indication from the Commission's report that they consulted any individual with expertise about mental disorders of older people. The NOPWC was the only organisation mentioned which advocated wholly for older people²⁰⁷ although its expertise was not specific to mental health. What guided the Commission in their pronouncements on older people is unclear from published sources. The Commission's archive is vast²⁰⁸ and the catalogue gives no clues; a separate study would be necessary to be conclusive on this matter.

According to Kathleen Jones, the Commission may have been under some pressure to exclude older mentally ill people with organic conditions from their report.²⁰⁹ The Commission's 'main questions for consideration' included whether to recommend different procedures for admitting older people, because 'senile confused patients' often did not refuse admission, but nor did they comprehend enough to consent to it.²¹⁰ This showed some appreciation of the issues, but precisely how to deal with the patient's lack of understanding, rather than refusal, remained unclear. The Commission, however, recommended including older people in the new legislation; the term 'mental illness' should

²⁰⁷ Percy Report, 304-306

²⁰⁸ Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission): minutes, papers and reports (44 files) (TNA, MH121)

²⁰⁹ Kathleen Jones, *Mental Health and Social Policy 1845-1959* (London: Routledge and Kegan Paul, 1960) 184

²¹⁰ Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 'Main questions for consideration' 1 (TNA, MH 121/8)

include ‘mental infirmity of old age’²¹¹ and there should be no upper age cut off for compulsory admission procedures.²¹²

The MHA perpetuated the administrative division between hospital and community mental health services introduced by the NHS Act. This risked undermining continuity of care, which could be detrimental especially for older patients with complex needs.²¹³ However, much of the MHA was positive. Constructive statements included that older people who might benefit from skilled mental hospital treatment ought not be denied it: treatment should depend on the illness, not on age.²¹⁴ It recommended provision of local community and out-patient services.²¹⁵ Unfortunately, the key recommendation, that responsibility for providing community mental health services should be mandatory upon local authorities,²¹⁶ was not enforced.²¹⁷ The Commission also recommended that, whenever possible, mentally ill patients, including ‘elderly senile patients’, should be admitted to mental or general hospitals informally in the same way as patients with any other illness.²¹⁸ For older people, facilitating admission to psychiatric wards located in the same general hospitals as geriatric units, might improve collaboration with geriatricians.

Committee of Enquiry into the cost of the National Health Service (Guillebaud Report) 1956

A third enquiry, chaired by Claude Guillebaud, a Cambridge economist, investigated the financial state of the NHS. The report highlighted funding for the ‘care of the aged’ but hardly mentioned mental health. Guillebaud

²¹¹ Percy Report, 6

²¹² *Ibid.* 112-113

²¹³ Duncan Macmillan, ‘Community mental health services and the mental hospital’ *World Mental Health* (1961) 13: 46-58 46

²¹⁴ Percy Report, 27

²¹⁵ *Ibid.* 7, 29-31

²¹⁶ *Ibid.* 19, 241-242

²¹⁷ RCPsych, ‘Recommendations on the implementation of the White Paper “Better Services for the mentally ill”’ C11/76, EFCC4/76, 2 (TNA, MH 154/935)

²¹⁸ Percy Report, 7

commented that, overall, services for older people were inadequate, demand greatly exceeded supply and administrative changes would not overcome the difficulties.²¹⁹ In the context of relatively stable NHS costs during the previous five years (Fig 8), the committee judged additional funding for the needs of the expanding older population to be affordable although ‘it would be unrealistic to suppose that the deficiencies in the services ... can be made good overnight’.²²⁰ It concluded with a much needed but unheeded message:

the health authorities concerned should make sure that the needs of the aged are given their due priority in the allocation of additional resources and are not overlooked amid the pressure of other competing needs.²²¹

Concerning mental health and geriatrics, it was not known whether alternatives to admission, such as day hospitals or community services, could produce savings. Farndale noted the high cost of ambulances to take people to and from day hospitals.²²² He found no clear evidence of excessive cost, nor evidence of day hospitals ‘saving’ beds,²²³ although another study concluded that they did.²²⁴ He identified two day hospitals producing direct financial savings, the ‘Worthing experiment’, and Cosin’s day hospital.²²⁵ These enthusiastically organised, carefully evaluated schemes indicated what might be achieved.

²¹⁹ Guillebaud Report, 214-215

²²⁰ *Ibid.* 219

²²¹ *Ibid.* 219

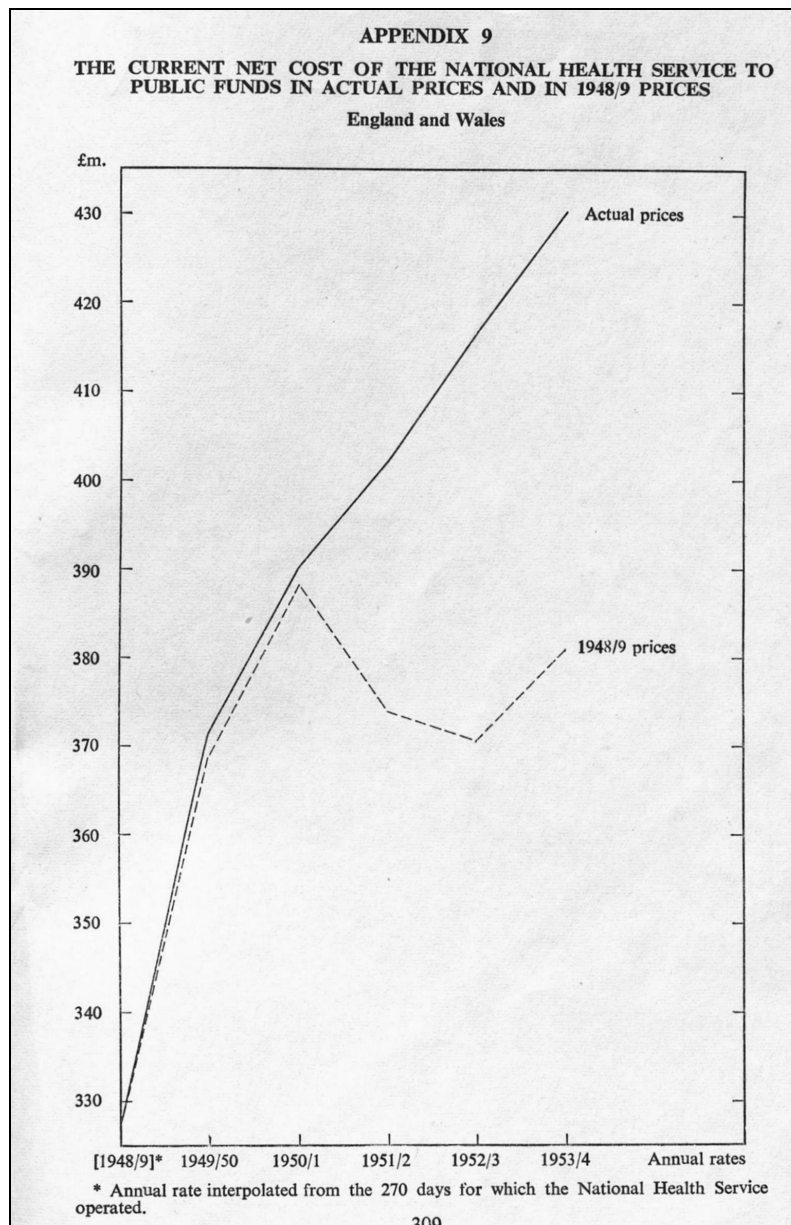
²²² Farndale, *Day Hospital*, 77

²²³ *Ibid.* 78, 110

²²⁴ Boucher Report, 24

²²⁵ Farndale, *Day Hospital*, 110-111

Fig 8. The cost of the NHS 1948-54



Source: Guillebaud Report, 309 (Copyright permission: Open Government Licence, OGL)²²⁶

Some matters raised by Guillebaud's committee overlapped with those of the Royal Commission, particularly relating to discharge from hospital. There were various difficulties ideologically and pragmatically. People suffering from degenerative disorders, especially dementia characterised by loss of intellectual function which impaired their ability to organise their lives and maintain their own safety, might never be able to return home independently,

²²⁶ TNA, 'Open government licence for public sector information'
<http://www.nationalarchives.gov.uk/doc/open-government-licence/> accessed 29.3.2013
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requiring instead long-term supervision in an institution. Although the NHS funded complex long-stay care, local authorities or means tested benefits funded most other long-stay care.²²⁷ Guillebaud commented that NHS funding would only apply to ‘the senile confused or disturbed patient ... unfit to live a normal community life in a welfare [residential] home.’²²⁸ Thus, for less disruptive variants of the *same condition*, older people who had been able to save for their latter years were expected to contribute to means tested ‘social’ care. Severity criteria also applied to chronic physical illnesses such as Parkinson’s disease and multiple sclerosis. Whereas symptom severity was not a criterion for free health care for acute illnesses, such as in primary care or in accident and emergency departments, it was a factor in determining who should pay for care for chronic conditions. This was inequitable, and especially affected older people. Robin Means and Randal Smith’s study of the health and social care interface identified concerns expressed in the 1950s that chronic disorders should face these arbitrary and subjective divisions.²²⁹ They commented that information on the position of government officials on the subject was scant, although relevant Ministry of Health files were not available for public inspection at the time of their research.²³⁰

A system of free health care and means-tested social care, inherited from the Poor Law, reviewed at a time of economic austerity probably disadvantaged those with chronic physical and mental conditions. There was little lobbying of the government on behalf of people not designated to receive NHS care; charities campaigning for chronic physical disorders in the 1950s and ‘60s focussed on research and direct practical support rather than on welfare benefits.²³¹

²²⁷ Percy Report, 207

²²⁸ Guillebaud Report, 216

²²⁹ Means and Smith, *Welfare Services*, 190-198

²³⁰ *Ibid.* 193

²³¹ Elizabeth Forsythe, *Living with Multiple Sclerosis* (London: Faber, 1979) 126-131; Sandra Rennie, ‘The voluntary sector: a case study – the Parkinson’s Disease Society 1969-1993’ (BSc Dissertation, University College London, 1993)

Guillebaud's report was unpalatable to the Conservative government who had expected it to provide evidence of excessive expenditure to enable tighter retrenchment of the NHS.²³² The needs of older people were hotly debated in the House of Commons in 1957, with some MPs supporting greater expenditure. Among them, Robert Mellish (Labour) spoke passionately about the lack of care for older people, commenting: 'It is no good talking about day hospitals and similar provision for old folk if money is not provided for the purpose'.²³³ Historian Virginia Berridge has argued that: 'The rigid resource constraints established during the first decade of the service established norms against which the NHS has been measured ever since'.²³⁴ Webster, without giving specific examples, commented on the rigorous control of NHS expenditure with the result that: 'innovation, even if cost effective, tended to be arbitrarily ruled out'.²³⁵

Guillebaud's recommendation of additional finance did not materialise. Services for chronic disease in older people competed for the same pot of money as services for younger and acutely ill people. Some older people undoubtedly benefited from high-tech acute hospital services, but many more could have benefited from low-tech, age- and needs-appropriate, generally low cost, rehabilitative interventions, but those were not forthcoming.

Services Available to the Chronic Sick and Elderly (Boucher Report) 1957

The fourth report, a survey of facilities for 'chronic sick and elderly' patients in England and Wales, was compiled by Charles Boucher, Senior Medical Officer at the Ministry of Health. He was regarded by some geriatricians as an ally.²³⁶ Although he acknowledged that mental disorders in older people were a large and complex problem, his survey excluded mental hospitals.²³⁷ This was a

²³² Webster, *Political History*, 32-33

²³³ Robert Mellish, 'Chronic Sick and Elderly (Services)' HC Deb 29.11.1957 *Hansard* Vol. 578 cc1443-525 1464 http://hansard.millbanksystems.com/commons/1957/nov/29/chronic-sick-and-elderly-services#S5CV0578P0_19571129_HOC_14 accessed 21.9.2011

²³⁴ Virginia Berridge, *Health and Society in Britain since 1939* (Cambridge: CUP, 1999) 25

²³⁵ Webster, 'The elderly' 175

²³⁶ Cosin (BLSA)

²³⁷ Boucher Report, 7, 46-48

major drawback from the psychogeriatric perspective, perhaps signifying its low status on the hierarchy of government priorities. Geriatric services fared only a little better. Mellish criticised Boucher's survey: it was 'limited to the services available and was not a fundamental examination of the problem itself' and it lacked 'any proposals for a comprehensive national approach to this problem'.²³⁸ Welshman, in his study of public health and older people, commented on the tendency of the Ministry of Health to describe existing services reassuringly without addressing the corresponding, and more difficult, question of whether they met need.²³⁹

Boucher raised another important issue, whether or not to segregate or integrate mentally ill people into ordinary residential homes.²⁴⁰ Segregation had been proposed largely to protect the sensibilities of mentally well people,²⁴¹ and the Institute of Almoners advocated the 'removal of mental cases to separate blocks'.²⁴² Charlotte Greenhalgh, writing on psychological aspects of the lives of older people in mid-twentieth century Britain, cited interviews with care home superintendents in the 1950s, noting another form of discrimination: within integrated homes, confused and infirm people had the least good accommodation, and were least likely to have their emotional needs attended to.²⁴³ Rowntree recommended mixing people, as some older people liked to help frailer residents,²⁴⁴ but mixing resembled the workhouses. The 1940s and 1950s heralded the modern debate on segregation *versus* integration in old age homes.

²³⁸ Robert Mellish, HC Deb 'Chronic Sick' 1443

²³⁹ John Welshman, 'Growing old in the city: public health and the elderly in Leicester 1948-74' *Medical History* (1996) 40: 74-89 77

²⁴⁰ Boucher Report, 46-47

²⁴¹ William Stanyon in the *Manchester Guardian* quoted in Samson, *Old Age*, 48; James Affleck, 'Psychiatric disorders' 34

²⁴² Institute of Almoners, *Memorandum on the Care of the Chronic Sick* (May 1946) 23 (BMAA, Committee on Care and Treatment)

²⁴³ Charlotte Greenhalgh, 'An age of emotion: expertise and subjectivity in old age in Britain, 1937-1970'. Chapter: 'Old age policy in practice: the residential home' (DPhil Thesis (Draft), University of Oxford, 2012) 30

²⁴⁴ Rowntree, *Old People*, 64

The Royal Commission and the Boucher, Guillebaud and Phillips committees overlapped so one could not build on the others' models, arguments or conclusions. Boucher's report probably paved the way for ministerial circulars on hospital and local authority responsibilities for care in old age, but they concentrated on physical wellbeing.²⁴⁵ Webster was critical: 'the absence of a single connected review of services for the elderly seemed unforgivably negligent'.²⁴⁶

One option to deal with the complex scenario of health care for older people was to ignore it; it was invisible to most of society, with unwell, frail older people generally hidden in their homes or in institutions. Mellish summed up the impressions made by the recent reports: older people in the 1950s had been brought up before the NHS, worked through the depression of the 1930s and suffered two world wars:

Not once in their lifetime will they have had first-class standards, and yet all we have had from the Government is a survey to show what facilities are available.²⁴⁷

Conclusions

Robinson's and Cosin's services for older people, the outcome of treatment at the Bethlem-Maudsley, the reduction of hospital admissions indicated in the 'Worthing experiment' and the research of Roth and others increased knowledge. These findings, against a background of emerging geriatric services, indicated the potential to improve treatment and care and reduce the morbidity and mortality which Cook *et al* described. Considering the magnitude of the concern, research findings were slow to be adopted, or even discussed, by the government. Some suggestions about older people's health needs were forthcoming in government circles, such as in the Royal Commission's report and from individual MPs, but there remained a fear of insurmountable cost related to longevity, despite expert economic analysis

²⁴⁵ Denham, 'Geriatric medicine' 324; MoH, *Geriatric Services*; MoH, *Local Authority Services for the Chronic Sick* Circular 14/57 (London: MoH, 1957)

²⁴⁶ Webster, 'The elderly' 174

²⁴⁷ Mellish, 'Chronic Sick' 1457-1467

indicating otherwise.²⁴⁸ This fear may have kept older people low on the public agenda and inhibited planning. Planning was not made easier by post-war austerity, but even with greater prosperity towards the late 1950s, older people's provision changed little.

Many chronic sick and mentally unwell people of all ages remained in inadequate accommodation, especially in dilapidated Victorian mental hospitals or former workhouses.²⁴⁹ Mental hospital beds were increasingly occupied by people over 65. There were entrenched pessimistic attitudes towards older people and their ability to benefit from interventions. Acute and technical interventions mainly for younger people were valued above treatments for chronic disorders of mainly older people. Clinically, physical and mental conditions in older people were inadequately investigated, diagnosed and treated.

Apart from a handful of geriatricians and psychiatrists, the medical profession did little to improve psychogeriatric provision. Most psychiatrists were at best indifferent. The Ministry of Health appeared concerned but uncommitted to the cause. There was no government strategic direction, leadership or delineated line of responsibility. Social welfare and NHS support were lacking, both directly to enable people to remain at home as independently as possible and for the families who cared for them. Guillebaud's recommendation, rejected by the government, that appropriately funded health care for older people was feasible, reinforced the notion that lack of motivation to provide services rather than realistic financial consideration was a huge stumbling block.

²⁴⁸ Guillebaud Report; Brian Abel-Smith, 'The cost of the support of the aged' 11-16. In: IAG, *Fourth Congress*, Vol. iii (Fidenza: Tito Mattioli, 1957)

²⁴⁹ Guillebaud Report, 34

Chapter 3

Changing horizons until 1970

The root cause of the national geriatric problem as we know it today is not shortage in money, equipment or personnel, but a defective national attitude to old age, in which the medical and nursing professions share.

Dr Thomas Rudd, 1967¹

Setting the context: prosperity, autonomy, independence and retirement

Britain in the 1960s experienced an increase in prosperity and a new societal emphasis on human rights.

Despite the prosperity, financial concerns continued. From the beginning of the decade the value of the pound dominated political and economic thinking.² Under the Labour government, which came into office in 1964, in 1967 the pound was devalued and austerity measures were introduced to deal with the balance of payments crisis. Prescription charges, which had been abolished in 1965 were re-introduced in 1968, but people over 65 years were exempt.³ The cost of health care increased in real terms and as a proportion of Gross Domestic Product (GDP), from 3.9% in 1960 to 4.5% in 1970.⁴

New legislation about race relations, homosexuality, abortion and suicide⁵ reflected the anti-discrimination agenda and more liberal attitudes regarding personal autonomy and individuality. Marked social change was evident in many places across the globe. The Cultural Revolution began in China in 1966. The Prague Spring and demonstrations in the UK, Paris, Washington DC and Germany took place in 1968. There were different reasons for the protests in different places, but common concerns included the Vietnam War, equality and

¹ Thomas Rudd, *Human Relations in Old Age: a handbook for health visitors, social workers and others* (London: Faber and Faber, 1967) 65

² Bernard Levin, *The Pendulum Years* (London: Jonathan Cape, 1970) 135-136

³ Kenneth Robinson, 'Prescription Charges' HC Deb 19.3.1968 *Hansard* Vol. 761 cc225-228 227 <http://hansard.millbanksystems.com/commons/1968/mar/19/prescription-charges> accessed 16.3.2013

⁴ OECD, 'Health expenditure as a share of GDP, 1960-2009, selected OECD countries' <http://dx.doi.org/10.1787/888932523215> accessed 13.3.2013

⁵ Race Relations Act 1965, chapter 73; Sexual Offences Act 1967, chapter 60; Abortion Act 1967, chapter 87; Suicide Act 1961, 9 and 10 Eliz 2, chapter 60

autonomy.⁶ Occurring virtually simultaneously, the demonstrations reflected shifting expectations in rapidly changing societies. They occurred concurrently with the publication of inquiries into widely publicised scandals of abusive institutional care of older and mentally handicapped people in Britain.⁷ It was unlikely that the abuses were new, rather the valuing of personal liberty may have enhanced awareness of the lack of autonomy of others and the inadequacies of the welfare state.

Principles of 'normalisation'⁸ were developing for mentally handicapped people, allowing them to live as normal a life as possible, acknowledging risks but avoiding over-protectiveness. Older people, despite their experience of life, were still perceived as inevitably vulnerable. Some perception of vulnerability could be useful; if an older person could not manage alone, family and friends might provide valuable support, although that help might be rejected in the individual's resolve to remain independent.⁹ At times, older people's wishes to remain at home relatively autonomously were not taken into account, unlike contemporaneous changes favouring free choice for younger people, even when this entailed taking risks. Dependency may have been encouraged by over protectiveness.¹⁰ This may have equated with care and respect within families, but was less likely in tightly regulated institutions.

The emergence of mass retirement in the mid-twentieth century, especially for the working classes, was a complex issue, explored in detail by Thane.¹¹ In her view, it was one of several twentieth century changes which 'increasingly

⁶ Albert Hirschman, 'Politics' 29-40. In: *The Ideas that Shaped Post-war Britain* ed. David Marquand, Anthony Seldon (London: Fontana Press, 1996) 30-31

⁷ NHS, *Findings and Recommendations Following Enquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals* Cmnd. 3687 (London: HMSO 1968); DHSS, *Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and other Irregularities at the Ely Hospital, Cardiff* Cmnd. 3975 (London: HMSO, 1969)

⁸ Anne Boucherat, 'Normalisation in mental handicap – acceptance without questions?' *Psychiatric Bulletin* (1987) 11: 423-425

⁹ A Norman Exton-Smith, 'Investigation of the aged sick in their homes' *BMJ* (1952) ii: 182-186 186

¹⁰ Zofia Butrym, 'Introduction to a discussion on casework with geriatric patients' *Almoner* (1963) 15: 325-332 326

¹¹ Thane, *Old Age*, 385-406

defined old people as a distinct social group defined by marginalisation and dependency'.¹² If retirement was associated with negative views of older people, it might have influenced provision of health and welfare services for them. Retirement was usually linked with a marked fall in personal income and reliance on the state pension. Sociologist and campaigner for social justice Peter Townsend cited one estimate that up to 75% of retired people had incomes low enough to qualify for means tested National Assistance.¹³ With poverty came disadvantageous health inequalities.

New social constructs for old age, such as 'ageism',¹⁴ 'gerontophobia',¹⁵ and 'structured dependency'¹⁶ identified unhelpful attitudes and practices. The media had the potential to educate and contribute to debate on ageism but did little to challenge this form of discrimination; if anything the media upheld it. In documentaries and sitcoms, chronic illness in older people had little media appeal compared with dramatic life saving procedures or the health of children. Popular drama about old people was limited. One older character, Alf Garnett, in the BBC television serial, *Till Death Us Do Part*, was intolerant, bigoted and ridiculed, contributing little to attractive images of older people. Emphasis on youth culture and modernity worked against tackling issues around old age. These issues remained emotionally uncomfortable for many people who psychologically distanced themselves from the illnesses and infirmities of old age until they personally encountered them. In 1965, the rock band 'The Who' probably conveyed many people's views: 'I hope I die before I get old'.¹⁷ The Beatles' song asked: 'Will you still need me, will you still feed me when I'm sixty-four?', reflecting on old age associated with contented companionship, but with lower personal value, less practical ability and lack of income.¹⁸

¹² Thane, *Old Age*, 406

¹³ Peter Townsend, *The Family Life of Old People* (Harmondsworth: Penguin Books, 1963) 186

¹⁴ Butler, 'Age-Isms'

¹⁵ Alex Comfort, 'On gerontophobia' *Medical Opinion and Review* (1967) 3: 9: 30-37

¹⁶ Peter Townsend, 'The structured dependency of the elderly: a creation of social policy in the twentieth century' *Ageing and Society* (1981) 1: 5-28

¹⁷ Pete Townshend / The Who, 'My Generation' (The Who, 1965)

¹⁸ Paul McCartney, John Lennon / The Beatles, 'When I'm 64' (The Beatles, 1967)

Popular expectations of old age were modest. From the government's perspective, old age was seen as less of a problem since the birth-rate had risen and was expected to remain high. 'Baby boomers' were reaching working age, so more people were available to look after older people and low unemployment reduced concerns about supporting dependent people of working age. The needs of older people were easy to ignore.

Public attitudes and activity about equitable mental health care in old age

In the 1960s, drivers for equality were usually activists from within the groups discriminated against or from organisations set up to promote equality. For example, disabled people campaigned for better state provision to help meet the costs of their disability and practical interventions to allow them to live more fulfilling and active lives. Their work was helped by sympathetic MPs and resulted in the Chronically Sick and Disabled Person's Act, 1970.¹⁹ It was a groundbreaking first step.

Disability discrimination campaigning differed from old age campaigning. Relatively little campaigning was done by older people themselves.²⁰ This may have related to the stoical nature of many older people. Townsend noted that they were rarely self pitying and 'bore pain with surprisingly little fuss'.²¹ Older mentally ill people were unlikely to have been able, and their carers too busy, to campaign directly for better provision.

Organisations such as the NOPWC aimed to improve the lives of older people generally, mainly by practical philanthropic support and lobbying the government. Help the Aged (founded 1961) emphasised social support and relief of poverty.²² NAMH established a care home and promoted older people's welfare.²³ An issue of their journal, *Mental Health*, in 1963 was

¹⁹ Simon Millar, 'Disability' 163-188. In: *Unequal Britain* ed. Pat Thane (London: Continuum, 2010) 168; Chronically Sick and Disabled Person's Act 1970, chapter 44

²⁰ Pat Thane, 'Older people and equality' 2-28. In: *Unequal Britain* ed. Thane, 13

²¹ Townsend, *Family Life*, 28

²² Age UK, <http://www.ageuk.org.uk/about-us/who-we-are/our-history/> accessed 30.4.2013

²³ Noel Harris, 'Parnham' *Mental Health* (1963) 21: 218-221

devoted to older people. An editorial about their mental wellbeing, the importance of having interests and being useful to others was uncomfortably titled 'The elderly: "living and partly living"'.²⁴

There were still no organisations specifically advocating for mentally ill older people. Psychiatrist Peter Hays, who wrote *New Horizons in Psychiatry* for a lay readership, commented:

Old people suffer from having no one to speak up for them and a short voting life left, but the facilities provided for them at present seem worse than even these grave deficiencies warrant.²⁵

Townsend addressed the Association of Directors of Welfare Services in 1961. He asked:

Why, after 12 or 13 years' experience of post-war legislation, are the problems of the aged so insistent and disturbing and so far from amelioration, still less solution?²⁶

Geoffrey Gibbs, chairman of the NCCOP wrote in 1963:

In the years since the war a great deal has been said and written on the care of the aged but only a small proportion of it has touched on the care of the mentally infirm aged.²⁷

Townsend's and Gibbs's concerns fit the scenario of no major changes in services for older people, especially those with mental disorders. Townsend suggested that if expenditure was not switched from institutional to domiciliary services, 'future social historians may well select this as the most striking failure of social policy' in the post-war years.²⁸

²⁴ Anon. 'The elderly: "living and partly living"' *Mental Health* (1963) 21: 210-211

²⁵ Peter Hays, *New Horizons in Psychiatry* (Harmondsworth: Penguin Books, 1964) 275

²⁶ Anon. 'Old people's welfare services' *Almoner* (1961) 14: 379

²⁷ Geoffrey Gibbs, 'Foreword' 3-4. In: GWH Townsend, AN Exton-Smith, The Lady Norman, Felix Post, Tom Wilson, *Accommodation for the Mentally Infirm Aged: a report to the governors of the National Corporation for the Care of Old People by a committee appointed for this purpose* (London: NCCOP, 1963) 3

²⁸ Anon. 'Old people's welfare'

Anti-psychiatry and change in mental health provision

An important force for change in mental health provision was the anti-psychiatry movement. Their philosophy was expounded by a handful of powerful writers from several countries, including Thomas Szasz,²⁹ Ken Kesey,³⁰ RD Laing³¹ and Erving Goffman.³² Linked with ideas about personal autonomy, anti-psychiatry held that so called psychiatric illness was not biological, despite emerging scientific evidence supporting biological aetiologies, but was defined by society through social, political and legal means.³³ Those so labelled were victims of misguided diagnosis and inappropriate physical treatment.³⁴

Anti-psychiatry identified shortcomings in many aspects of psychiatric practice. However, their focus was almost entirely on young people, especially those with schizophrenia. Laing surmised that schizophrenia was the response of individuals to living in emotionally unliveable family situations.³⁵ His clinical vignettes described people under 40 years.³⁶ He did not appear to consider the aetiology of mental disorders in old age. Goffman hardly mentioned older people in his sociological monographs on discrimination.³⁷ Kesey's novel, *One Flew over the Cuckoo's Nest*, about an American mental hospital, explored the predicament of mainly younger men despite older people occupying increasing numbers of mental hospital beds in the USA³⁸ as in the UK. If the anti-

²⁹ Thomas Szasz, *The Myth of Mental Illness* (New York: Dell, c.1961)

³⁰ Ken Kesey, *One Flew over the Cuckoo's Nest* (London: Methuen, 1963)

³¹ RD Laing, *The Divided Self: a study of sanity and madness* (London: Tavistock Publications, 1960)

³² Erving Goffman, *Asylums: essays on the social situation of mental patients and other inmates* (New York: Anchor Books, 1961)

³³ Shorter, *History of Psychiatry*, 272-277

³⁴ David Cooper, 'Introduction' vii-ix. In: Michel Foucault, *Madness and Civilisation* (Oxford: Routledge, 1989)

³⁵ RD Laing, Aaron Esterson, *Sanity, Madness and the Family* (London: Penguin Books, 1964) 15-27

³⁶ *Ibid.* 31-264

³⁷ Goffman, *Asylums*; Erving Goffman, *Stigma: notes on the management of spoiled identity* (New York: Simon and Schuster, 1963)

³⁸ Benjamin Malzberg, 'The frequency of mental disease: a study of trends in New York State' *Acta Psychiatrica Scandinavica* (1963) 39: 19-30 26

psychiatry movement influenced provision of services for older people, that was incidental to its main objectives.³⁹

The *Hospital Plan* and the district general hospital

In 1961, Minister of Health Enoch Powell, gave an optimistic address to a NAMH conference, his so called ‘Water Tower’ speech, named after his reference to the ‘gigantic water-tower ... rising unmistakable and daunting out of the countryside’⁴⁰ (Fig 9) characteristic of the ‘psychiatric’ hospitals.⁴¹

Fig 9. Shenley Hospital water tower seen from Napsbury Hospital, Hertfordshire⁴²



Source: Photographed by author, 2012

Powell touched on the wellbeing of older people and emphasised the need to provide more community services.⁴³ He spoke about the Ministry of Health’s *Hospital Plan*, a national scheme for which fresh capital sums were allocated to build new district general hospitals (DGHs). DGHs would include short-stay psychiatric units.⁴⁴

³⁹ Digby Tantam, ‘The anti-psychiatry movement’ 333-347. In: *150 years* ed. Berrios and Freeman

⁴⁰ Enoch Powell, ‘Opening speech’ (‘Water Tower’) 5-10. In: *Emerging Patterns for the Mental Health Services and the Public: proceedings of a conference at Church House Westminster, 9-10 March 1961* (London: NAMH, 1961) 6

⁴¹ ‘Mental’ hospitals renamed ‘psychiatric’ hospital or just ‘hospital’ by MHA 1959; Martin, *Adventure*, viii

⁴² Both hospitals closed c.1998

⁴³ Powell, ‘Water Tower’ 8-9

⁴⁴ *Ibid.* 6; MoH, *A Hospital Plan for England and Wales* Cmnd. 1604 (London: HMSO, 1962) 6

Plans for DGHs were encouraged by some senior physicians, such as professor of social medicine Thomas McKeown. He proposed the ‘balanced hospital community’ i.e. providing hospital care for all disorders within a locality at a single DGH with appropriate facilities, staff, equipment, and good community-hospital relationships.⁴⁵ This contrasted with the existing distribution of mainly separate psychiatric, acute and chronic hospitals. However, not all health and social care leaders fully supported the *Hospital Plan*. Townsend, for example, was concerned that it depended too much on unproven assumptions about demands for hospital care rather than the needs of the population, especially older people.⁴⁶

The MHA permitted, but did not require, establishment of adequate community mental health services⁴⁷ and DGH psychiatric departments.⁴⁸ The *Hospital Plan* seemed to encourage them and optimistically alluded to the success of ‘new methods of treatment combined with changed social attitudes’.⁴⁹ McKeown and psychiatrist Robert Cawley hoped that treating mental illness in a DGH would reduce stigma.⁵⁰ This linked to a moral imperative to integrate mental illness into the DGH for all age groups. However, for older people, there was also a medical need for integration because of the high frequency of co-existing, often treatable, physical disorders. Integration for older people’s services was complicated by ambiguities in the *Hospital Plan* concerning psychiatric treatment within geriatric units. Geriatric units would ‘cover the provision required for the elderly confused who do not need treatment in a psychiatric hospital’.⁵¹ However, specific plans for older people with

⁴⁵ Thomas McKeown, *Medicine in Modern Society* (London: George Allen and Unwin, 1965) 115-126

⁴⁶ Peter Townsend, ‘A national survey of old people in psychiatric and non psychiatric hospitals, residential homes, and nursing homes’ 223-232. In: *Psychiatric Hospital Care: a symposium* ed. Hugh Freeman (London: Baillière, Tindall and Cassell, 1965) 223

⁴⁷ MHA (1959), 3-4

⁴⁸ *Ibid.* 3

⁴⁹ MoH, *Hospital Plan*, 5

⁵⁰ Robert Cawley, Thomas McKeown, ‘Services for the mentally ill in a balanced hospital community’ 134-155. In: *Trends in the Mental Health Services* ed. Hugh Freeman, James Farndale (Oxford: Pergamon Press, 1963) 135

⁵¹ MoH, *Hospital Plan*, 5

functional mental illness were not mentioned, nor were older people whose confusion could not be managed in geriatric wards. Provision for them may have been implied under 'Beds for mental illness',⁵² although two years later a Ministry of Health memorandum on the care of 'mentally disordered' people, 'assumed' older people would be dealt with 'in the context of the elderly generally'.⁵³ No reasons were given to support that assumption. Lack of clarity in defining responsibility for psychogeriatric services risked neglecting them.

In addition to Powell's and McKeown's expressed intentions to integrate community and hospital services,⁵⁴ the CMO's annual report for 1960 emphasised integrating services for 'mentally enfeebled old people'.⁵⁵ The term 'integration', however, was ambiguous. To some it meant ensuring high quality coordinated services with good continuity of care, to provide patients with a seamless service. To others it meant re-organising services in order to squeeze more from what was already available without additional resources. Given demographic trends, the latter seemed unrealistic. Little was offered by central government, but nor were requests from the periphery to allocate more resources readily identifiable. Perhaps those advocating better provision for older mentally ill people were conditioned by previous experience or government rhetoric not to request more resources, or, for those dedicated to providing services within the NHS, discussing cost was an anathema: health care was a right, paid for through taxation and provided on the basis of need. Others might have thought that costs would not need discussion since community care avoided the major overheads of old buildings and institutional administration and thus would be cheaper or 'at least be no more expensive' than psychiatric hospitals, a view of some government officials even into the 1980s.⁵⁶

⁵² *Ibid.* 5

⁵³ MoH, 'Care of the mentally disordered', memo, anon. to Mr Dodds, 4.9.1964, D/M150/01 (TNA, MH 154/11)

⁵⁴ Powell, 'Water Tower' 8; Cawley and McKeown, 'Services for the mentally ill'

⁵⁵ MoH, *Report for the Year 1960*, 98

⁵⁶ DHSS, 'Care in the community': briefing for press conference' 1982, 2 (TNA, MH 154/1562)

Broad NHS changes had the potential to improve treatment offered to older people. However, taking into account their chronic, complex and multiple health needs, it was unfortunate that they were often not identified within official plans. They remained a tagged-on group, despite their high usage of services. Providing for them appeared secondary to mainstream health objectives.

Psychiatric hospitals

Beds, admissions and discharges

Psychiatric hospital beds in England and Wales fell to 136,000 in 1960,⁵⁷ but the hospitals remained full, if less overcrowded.

Plans to close the psychiatric hospitals were vague, but a further reduction of 75,000 beds over 15 years was proposed for England and Wales. This figure was widely quoted, including in the 'Water Tower' speech.⁵⁸ It was derived from a study of psychiatric hospital bed requirements by Geoffrey Tooth, PMO at the Ministry of Health, and Eileen Brooke, a statistician. They predicted the decline on the basis of increased community services and reduced duration of admissions. For older people, they reiterated that bed numbers could be reduced further if alternative accommodation was available.⁵⁹ However, their estimate, based on theoretical alternative provision, was over optimistic and much debated.⁶⁰ Revised predictions, in 1962, included a caveat almost blaming patients for the overcrowding: 'one of the key problems of our mental hospitals – the elderly woman patient',⁶¹ when responsibility should have lain with the NHS and welfare services.

⁵⁷ Registrar General's Statistical Review, 13

⁵⁸ Geoffrey Tooth, Eileen Brooke, 'Trends in the mental hospital population and their effect on future planning' *Lancet* (1961) i: 710-713; Powell, 'Water Tower' 6; MoH, *Report for the Year 1960*, 96

⁵⁹ Rowntree, *Old People*, 73, 76; Tooth and Brooke, 'Trends' 712

⁶⁰ JSB Lindsay, 'Trend in mental-hospital planning and their effect on planning' *Lancet* (1962) i: 1354-1355; JA Baldwin, DJ Hall, 'Estimation of the outcome of a standing mental hospital population' *BJPSM* (1967) 21: 56-65

⁶¹ Brooke, 'Demand for psychiatric beds' 1211

Contrary to Tooth and Brooke's predictions, more older people were being accommodated in psychiatric hospitals. In 1960, there were 22,000 people aged over 75, 16% of total psychiatric hospital beds drawn from 4% of the population.⁶² In 1964, people over 65 occupied over 40% of beds in six regional health administrative areas and over 33% in the other nine areas (Fig 10), mainly on long-stay wards.⁶³ Between 1966 and 1973 the trend continued, from 42% to 47% of total psychiatric hospital beds occupied by people over 65.⁶⁴ High old age residence rates were even more staggering when one bears in mind that, according to one study carried out in 1961, around a quarter of all people over 60 admitted died within the first nine weeks,⁶⁵ little different from Cook *et al*'s study a decade earlier.⁶⁶ Compared to rates of psychiatric disorders identified by Roth,⁶⁷ functional mental illness was probably still under-diagnosed⁶⁸ and therefore untreated, which would have caused unnecessary suffering and prolonged admissions. Inadequacies of nursing were highlighted in Townsend's survey of residents over 65 in psychiatric and non-psychiatric hospitals, residential and nursing homes. Notably, he observed:

A considerable number possess capacities and skills which are held in check or even stultified. Staff sometimes do not recognise their patients' abilities, though more commonly they do not have time to cater for them.⁶⁹

⁶² Registrar General's Statistical Review, 16; OHE, 'UK Resident Population'

⁶³ MoH, *Activities 1964*, 8

⁶⁴ DHSS, *Psychiatric Hospitals and Units in England: in patient statistics from the mental health enquiry for the year 1973* (London: HMSO, 1976) 24

⁶⁵ John Connolly, M Lumsden, D Ross, 'The care of old people six months after admission to a psychiatric hospital' *Medical Officer* (1964) 111: 195-198 195

⁶⁶ Cook, 'Geriatric problem' 379

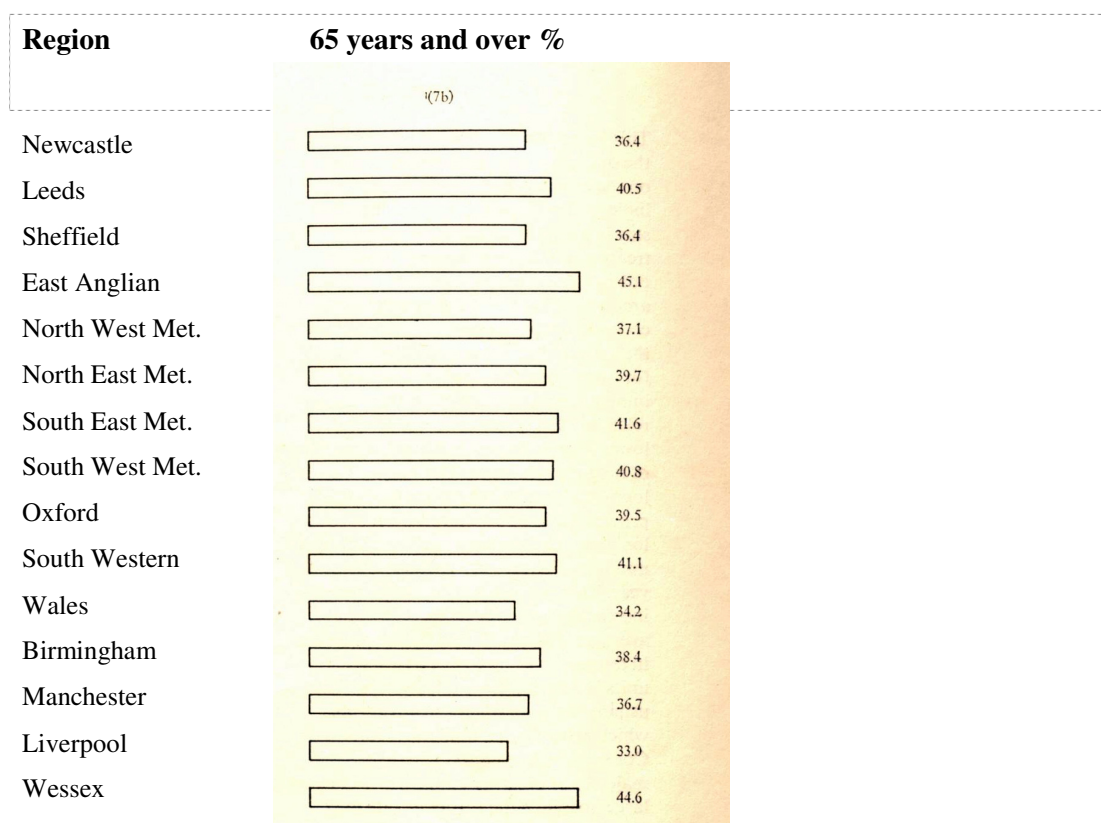
⁶⁷ Roth, 'Natural history' 286

⁶⁸ Connolly, 'Care of old people' 195

⁶⁹ Townsend, 'National survey' 229

This suggests that the social milieu of the institutions, with staff having neither the time nor the inclination for a rehabilitative approach,⁷⁰ may have increased dependency and prolonged duration of stay.

Fig 10. Percentage of resident patients in psychiatric hospitals age 65 years and over, 31.12.1963 (England and Wales)



Source: MoH, *Activities 1964*, 8 (Copyright permission: OGL)

In 1964, some wards in psychiatric hospitals accommodated over 70 people (Fig 11).⁷¹ A Ministry of Health report admitted that ‘their sheer size makes it virtually impossible to provide a satisfactory standard of nursing care’.⁷² From available statistics, it is difficult to know whether older people were placed disproportionately in these huge wards, since the bureaucratic net often failed

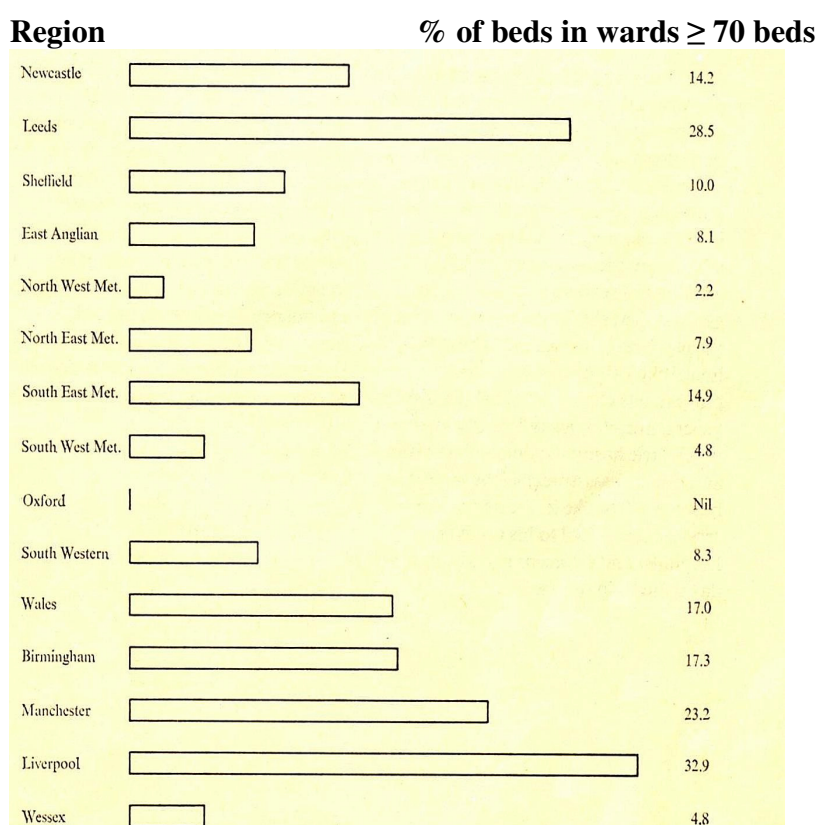
⁷⁰ Russell Barton, *Institutional Neurosis* (Bristol: John Wright and Sons Ltd, 1976) (1st ed 1959)

⁷¹ MoH, *Activities 1964*, 11

⁷² MoH, Central Health Services Council, *Psychiatric Nursing Today and Tomorrow: report of the Joint Sub-committee of the Standing Mental Health and the Standing Nursing Advisory Committees* (London: HMSO, 1968) 52

to trap age-specific data; the Ministry's report on psychiatric hospital activity from which figures 10 and 11 were taken included 39 tables only two of which indicated age.⁷³

Fig 11. Percentage of beds in psychiatric hospital wards of 70 or more in each region (England and Wales), 1964



Source: MoH, *Activities 1964*, 11 (Copyright permission: OGL)

It was difficult to understand the slow response of government to the demographic concerns, psychiatric hospital data and reiterated recommendations to achieve fundamental changes. Twenty years after the *Hospital Plan*, no major psychiatric hospital had closed.⁷⁴ Almost one-third of the old asylums were still open in 2000.⁷⁵ Patients with dementia were the last to leave.⁷⁶ Too often frustration rather than pro-active suggestions were voiced

⁷³ MoH, *Activities 1964*

⁷⁴ Barham, *Closing the Asylum*, 17

⁷⁵ Jeremy Taylor, Simon Cornwell, Peter Cracknell, 'The Asylums List' <http://www.thetimechamber.co.uk/beta/sites/asylums/asylum-history/the-asylums-list> accessed 15.5.2013

⁷⁶ Barham, *Closing the Asylum*, 22

by the medical profession: 'the most obtrusive problem in this [psychiatric] hospital is the institutionalised geriatric patient with little or no evidence of psychiatric illness', commented three senior hospital doctors in the *Lancet*.⁷⁷ Geriatrician Wilfred Fine also wrote in the *Lancet*, that psychiatric hospitals were becoming 'silted up' with older mentally ill people, at least partly because psychiatrists 'do not wish to treat' them.⁷⁸

How much of the 'silting up' reflected lack of professional interest, lack of opportunity for community care, inadequate diagnosis and treatment, or the assumption that rehabilitation was impossible, is unclear. Low expectations of what might be achieved would constrain improving services within and outside the hospitals. Negative attitudes, combined with psychiatric hospitals' typically rigid administrative hierarchy, did not promote change; psychiatrist Alex Baker noted a 'dynamic conservatism ... there are considerable forces which tend to maintain the status quo'.⁷⁹

Could admissions be avoided?

Older people admitted to psychiatric hospitals often did not need specific psychiatric interventions: 'mental hospitals have been used as dumping grounds, because of the inadequacy of suitable accommodation for the elderly' commented one psychiatrist.⁸⁰ Another psychiatrist, Cecil Kidd, contrasted the precipitants of hospital admission for younger and older people. The former were likely to be admitted to hospital purely because of need for treatment, the latter because 'either they cannot be treated *or cannot be tolerated at home*' (italics in original).⁸¹ Dr John Connolly in 1961, in a study of 153 people over age 60 admitted to St Nicholas Hospital, Newcastle upon Tyne, drew similar conclusions.⁸² The need for alternatives to long-stay hospital care was

⁷⁷ S Smith, G Gibb, A Martin, 'Metamorphosis of a mental hospital' *Lancet* (1960) ii: 592-593

⁷⁸ Wilfred Fine, 'Care of the elderly disturbed patient' *Lancet* (1963) i: 557

⁷⁹ Alex Baker, 'The Hospital Advisory Service' *News and Notes* (June 1973) 16-17 16

⁸⁰ M David Enoch, 'Care of the elderly disturbed patient' *Lancet* (1963) i: 1160-1161

⁸¹ Cecil Kidd, 'Rejection of the seventh age: society and the aged sick' *Almoner* (1962) 14: 452-457 457

⁸² John Connolly, 'The social and medical circumstances of old people admitted to a psychiatric hospital' *Medical Officer* (1962) 108: 95-100 95, 99

reinforced by a study by Kay and Roth collaborating with geriatrician Michael Hall. They concluded that, for the ageing population, the only viable option was to

develop programmes of care centred on well-coordinated community services whose aim must be to maintain the old person within his own home environment by every possible means.⁸³

Kay *et al*'s study emphasised that out-patient clinics, day-hospitals and comprehensive assessment units for physical and psychiatric disorders were vital; hospitals should support people at home as part of a programme of planned care rather than in response to crises.⁸⁴ The need for dedicated specific psychogeriatric provision was emphasised by the observation that older people were under-represented in general psychiatric day hospitals and demented people were often excluded from geriatric day hospitals.⁸⁵

Kidd's, Connolly's and Kay *et al*'s studies added to the accumulation of evidence about social factors precipitating admission and, frustratingly, to the backlog of un-implemented recommendations that had built up since the 1940s.⁸⁶ Psychiatric community assessments of older people and interventions including practical and emotional support and advice from statutory services remained uncommon,⁸⁷ despite the possibility of alleviating social difficulties, improving quality of life and potentially avoiding admissions.⁸⁸ In 1968, Guy Wigley, a public health physician, sent questionnaires to 172 local health authorities of which 163 responded, concerning services provided specifically for 'mentally infirm elderly people'. The study excluded community facilities provided by hospitals, which risked under-estimating total provision, but it

⁸³ David Kay, Martin Roth, Michael Hall, 'Special problems of the aged and the organisation of hospital services' *BMJ* (1966) ii: 967-972 971

⁸⁴ *Ibid.* 971, 972

⁸⁵ Tom Arie, 'Day care in geriatric psychiatry, 1978' *Age Ageing* (1979) 8: Supplement: 87-91 89

⁸⁶ e.g. Sheldon, *Social Medicine*, 196-198; Rowntree, *Old People*, 48-54, Lewis and Goldschmidt, 'Social causes'; DeLargy, 'Six weeks' 418; Cosin, 'Place of the day hospital' 557

⁸⁷ Connolly, 'Social and medical circumstances' 97

⁸⁸ Kay, 'Special problems'

identified local authority and voluntary community services; 13% provided day centres, 31% day hospitals, 8% work centres, 26% welfare homes and 12% social clubs.⁸⁹ Wigley remarked on the overall lack of provision and uneven distribution of services.

The White Paper *Health and Welfare* in 1963 urged local authorities to develop community services.⁹⁰ Welshman's critique of that document attributed under-development of relevant services to failure to provide adequate 'costings' and thus to establish a 'credible framework' for community care, and argued that 'the Ministry did not seem willing to coerce those whose services were of poor standard'.⁹¹ Lack of provision fitted with Connolly's comment emphasising inadequate coordination and accountability: 'There does not seem to be any agency or agent at present effectively finding and caring for the aged person who is mentally ill'.⁹²

Kidd: misplacement and joint psychiatric-geriatric units

Kidd raised concerns over the effects of placing older people in the 'wrong' bed. His study of people over 60 compared the outcomes for those suffering from psychiatric illness admitted to a geriatric hospital and those with physical illness admitted to a psychiatric hospital. People admitted to the wrong hospital appeared to have higher mortality than those matched for illness and hospital type.⁹³

Initially, Kidd's results induced alarm among those responsible for hospitals, and misplacement became a topic for investigation.⁹⁴ The alarm was possibly

⁸⁹ Guy Wigley, 'Community services for mentally infirm old people' *Lancet* (1968) ii: 963-966 963

⁹⁰ MoH, *Health and Welfare: the Development of Community Care: plans for the health and welfare services of the local authorities in England and Wales* Cmnd. 1973 (London: HMSO, 1963) iii

⁹¹ Welshman, 'Rhetoric and reality' 212-213, 225

⁹² Connolly, 'Social and medical' 99

⁹³ Cecil Kidd, 'Misplacement of the elderly in hospital: a study of patients admitted to geriatric and mental hospitals' *BMJ* (1962) ii: 1491-1495

⁹⁴ Kay, 'Special problems' 967; Gordon Langley, J Simpson, 'Misplacement of the elderly in geriatric and psychiatric hospitals' *Gerontologia Clinica* (1970) 12: 149-163; Malcolm

related to a High Court judgement in 1957 concerning adverse consequences of treatment in a mental hospital, which raised awareness of medical negligence.⁹⁵ There was a flurry of activity at the Ministry, fearful of the ‘serious consequences’ of misplacement.⁹⁶ Psychiatrist Rudolf Freudenberg, Senior PMO for mental health at the Ministry,⁹⁷ reiterated suggestions for combined psychiatric-geriatric assessment units in DGHs and teaching hospitals, and that psychiatrists and geriatricians should have adjacent wards in DGHs to facilitate collaboration.⁹⁸ His colleague at the Ministry, Dr Albertine Winner, was more sceptical. She commented that, ‘at the moment we are all arguing from theory, and, with the possible exception of Dr Cosin in Oxford, nobody has really tried out any of these ideas’.⁹⁹ Cosin still appeared to be a fairly isolated figure in this field, although the work of others, such as Post, Robinson and Macmillan, innovators of similar importance but less effective publicists, probably passed unrecognised. Unfortunately, Freudenberg’s suggestions were not followed up after he retired in 1965.¹⁰⁰ The ‘misplacement’ crisis passed, and brought no direct practical change, although some clinicians who later developed successful joint units attributed their ideas to Kidd.¹⁰¹

Kidd’s study was methodologically flawed. His conclusions were false, but that did not become apparent until 1975. Kidd had not matched his patients for illness severity; misplacement was probably associated with disorders for which assessment was most problematic, which were also likely to be those

Hodkinson, G Evans, A Mezey, ‘Factors associated with misplacement of elderly patients in geriatric and psychiatric hospitals’ *Gerontologia Clinica* (1972) 14: 267-273

⁹⁵ Bolam v. Friern Hospital Management Committee (1957): Queens Bench Division http://oxcheps.new.ox.ac.uk/casebook/Resources/BOLAMV_1%20DOC.pdf accessed 1.6.2010

⁹⁶ Anon. ‘Psychogeriatric assessment unit’ (c.1963) (WL/PP/RFK/C.8)

⁹⁷ Thomas Becker, Douglas Bennett, ‘Rudolf Karl Freudenberg – from pioneer of insulin treatment to pioneering social psychiatrist’ *HoP* (2000) 11: 189-211 195

⁹⁸ Rudolf Freudenberg to Drs Todd White, Winner and Boucher, memo, ‘Psychogeriatric Units’, 30.10.1963, 2 (WL/PP/RFK/C.8)

⁹⁹ Dr Albertine Winner to Dr Todd White and others, memo, 28.10.1963 (WL/PP/RFK/C.8)

¹⁰⁰ DB, ‘Rudolf Karl Freudenberg’ *Psychiatric Bulletin* (1983) 7: 215

¹⁰¹ Brice Pitt, Chris Silver, ‘The combined approach to geriatrics and psychiatry: evaluation of a joint unit in a teaching hospital district’ *Age Ageing* (1980) 9: 33-37 33

with the highest mortality.¹⁰² The overall impact of Kidd's study remained debatable: geriatrician Michael Denham thought it was fairly insignificant,¹⁰³ whereas psychogeriatrician Brice Pitt held the opposite view.¹⁰⁴

Some clinician-led joint units were developed and evaluated, providing an insight into their potential value. In Edinburgh, geriatrician James Williamson (later professor) and psychiatrist Frank Fish set up a 'delirium unit'.¹⁰⁵ Williamson reflected in 2008:

we sacrificed twelve beds, twelve precious geriatric beds ... Theoretically it was for people who had suddenly become confused ... But ... by the time we started analysing them – they were a very mixed bunch ... dementia ... depression ... pneumonias or anaemia ... we had quite an exciting time.
I learned a great deal ...
as a medical student – I think I saw two psychiatric patients and that was about all I knew about psychiatry.¹⁰⁶

Other physicians noted the importance of these units for education.¹⁰⁷ They also generated local interest: Bill Boyd, then a junior psychiatrist who subsequently became a leading psychogeriatrician in Scotland, remembered Fish, who was

full of enthusiasm ... about all the old ladies he'd been seeing. So I began to understand that there was something else going on in the world of psychiatry that I didn't know much about.¹⁰⁸

Although the above example is drawn from experience in Scotland, it exemplifies innovative collaborative practice which could have happened south

¹⁰² John Copeland *et al.* 'Evaluation of a psychogeriatric service: the distinction between psychogeriatric and geriatric patients' *BJPsych* (1975) 126: 21-29 21

¹⁰³ Michael Denham, interview by author (2007)

¹⁰⁴ Brice Pitt, interview by author (2006)

¹⁰⁵ Frank Fish, James Williamson, 'A delirium unit in an acute geriatric hospital' *Gerontologia Clinica* (1964) 6: 71-80

¹⁰⁶ Williamson, 'Witness' 23

¹⁰⁷ Kay, 'Special problems' 970

¹⁰⁸ Bill Boyd, 'Witness' 32

of the border. Fish and Williamson's unit was only funded as a short term research initiative, so was short lived.¹⁰⁹

Another joint unit was the geriatric-psycho-social ward, established by Macmillan in Nottingham, a beacon of collaboration between geriatrician, psychiatrist and social worker.¹¹⁰ It was probably unique, possibly related to difficulties of bringing together senior staff determined to share resources and collaborate.¹¹¹ Successful joint units probably partly depended on intangible variables such as individual personalities, reciprocal professional trust and the interests of local clinicians. When Macmillan retired, the collaborative ward ended,¹¹² similar to Freudenberg's retirement heralding a pause in the Ministry's interest. These examples support the hypothesis that individuals rather than ministerial policies led developments. Unfortunately, Macmillan died shortly after his retirement, before the developments in psychogeriatrics in the early 1970s.¹¹³

Joint units hardly materialised despite the misplaced concerns and recommendations for them by the Ministry of Health in 1950,¹¹⁴ WHO in 1959¹¹⁵ and the Department of Health and Social Security (DHSS) in 1970.¹¹⁶ Locating various specialists together in the same DGH in some ways reduced the need for them, as it was logistically easier to give an opinion on patients in wards located in the same, rather than in different, hospitals. The within-hospital reciprocal consultation model was part of established practice, and depended less on individual personality factors and ideals. However, numbers

¹⁰⁹ Williamson, 'Witness' 23

¹¹⁰ Eric Morton, ME Barker, Duncan Macmillan, 'The joint assessment and early treatment unit in psycho-geriatric care' *Gerontologia Clinica* (1968) 10: 65-73

¹¹¹ Eric Morton, interviewer Hazel Houghton (BLSA, 1991)

¹¹² Tom Arie, interviewer Hazel Houghton (BLSA, 1991)

¹¹³ HF, 'D Macmillan' *BMJ* (1970) i: 119

¹¹⁴ MoH, *Care of the Aged*

¹¹⁵ WHO, *Problems of Aging*

¹¹⁶ DHSS, *Psycho-Geriatric Assessment Units*

of geriatricians were rising (115 in 1964, 178 in 1968),¹¹⁷ contrasting with the mere handful of interested psychiatrists.¹¹⁸ The numerical imbalance between them probably contributed to making joint working unrealistic.

Other geriatric-psychiatric initiatives

Some geriatricians were concerned about older people's mental wellbeing, but movement towards widespread psychogeriatric service provision, via geriatrics or psychiatry, was lacking.

In the 1960s, overcrowding was a feature of geriatric wards as well as psychiatric hospitals. An anonymous *Medical Press* editorial commented:

especially in London and the Home Counties, the pressure of the aged on the available beds is becoming almost intolerable ... In one hospital ... it is the custom that when a practitioner seeks admission for a patient over the age of seventy, he is asked to undertake that, if and when the patient is better, that patient will go home, and unless the guarantee is given admission may well be refused, unless the case is desperate.¹¹⁹

Expecting a referring GP to ensure that carers remained willing, rent was paid or that a place in a welfare home remained available, was unworkable, even with good social work support. Such restrictions placed GPs in an unenviable position, and may have encouraged some of them to delay admission until 'the case is desperate', which might prolong the illness and reduce the likelihood of successful treatment and rehabilitation.¹²⁰

Scottish geriatricians were central to the development of their specialty in the UK, similar to the contribution of Scottish psychiatrists. In addition to Williamson, Bernard Isaacs was consultant geriatrician in Glasgow from 1961

¹¹⁷ John Brothwood, 'The organisation and development of services for the aged with special reference to the mentally ill' 99-112. In: *Recent Developments in Psychogeriatrics: a symposium* ed. David Kay, Alexander Walk (London: RMPA, 1971) 102

¹¹⁸ Arie and Jolley, 'Psychogeriatrics' 262

¹¹⁹ Anon. 'The aged in hospital' *Medical Press* (1961) 244: 303-305 304

¹²⁰ Howell, 'General practice' 337

until 1975, then professor in Birmingham.¹²¹ He was admired by psychogeriatricians for his skills in their specialty.¹²² William Ferguson Anderson was appointed the world's first professor of geriatric medicine in Glasgow in 1965.¹²³ Anderson, like Cosin, recognised the eclectic nature of his specialty, and the complex social, medical and psychiatric needs of his patients. He argued that geriatricians should train in psychiatry before reciprocal recommendations were proposed for psychogeriatricians to train in geriatrics.¹²⁴ Anderson and Isaacs organised a conference on geriatric medicine in 1964 in Glasgow, attracting delegates from across the UK and teachers such as Roth, Post, Robinson and local psychiatrists.¹²⁵ One of these, Robert Davidson, criticised psychiatry for 'lack ... of a common language'.¹²⁶ A common language was crucial for the health care of older people, especially to help geriatricians understand psychiatric concepts. This may appear one sided, but the Medical Act 1956¹²⁷ introduced supervised 'house-jobs' for all newly qualified doctors, six months in each of medicine and surgery before independent practice. Thus whereas psychiatrists would have worked in both medicine and surgery, consolidating their undergraduate knowledge, most geriatricians would not have worked in psychiatry. Coupled with the deficiencies of undergraduate training in psychiatry, lack of clinical psychiatric experience may have made it hard for them to acquire psychiatric concepts and skills.

Geriatricians wrote concise, pragmatic and optimistic textbooks, including about mental wellbeing in old age. *Human Relations in Old Age* (1967) by

¹²¹ Tom Arie, 'Isaacs, Bernard (1924-1995)', *ODNB*, OUP, 2008
<http://www.oxforddnb.com/view/article/58197> accessed 22.6.2010

¹²² David Jolley, 'Witness' 26

¹²³ Brocklehurst, 'Anderson'

¹²⁴ William Ferguson Anderson, 'Geriatrics – a specialty?' *Interdisciplinary Topics in Gerontology* (1970) 5: 44-49 44, 46, 48

¹²⁵ William Ferguson Anderson and Bernard Isaacs (ed.) *Current Achievements in Geriatrics: papers read at a conference on medical and surgical aspects of ageing held in Glasgow under the auspices of the Glasgow Postgraduate Medical Board, November 20-23rd 1963* (London: Cassell, 1964) 155, 178, 190

¹²⁶ Robert Davidson, 'The significance of paranoia' 184-189. In: *Current Achievements in Geriatrics* ed. Anderson and Isaacs, 184

¹²⁷ Medical Act 1956, 4 and 5 Eliz 2, chapter 76

Southampton geriatrician Thomas Rudd, was a humane, person-centred text written for a broad group of professionals. Rudd challenged common undesirable practices and attitudes. He wrote, for example, on practices relevant to caring for patients with dementia or delirium, such as the use of ‘cot-beds’, which could increase confusion ‘and serve merely to destroy still further the failing personality’.¹²⁸ He noted:

Our interest in the old person as an individual, rather than as a member of the undifferentiated herd, should be shown by our endeavours to interpret the meaning of the patient’s behaviour, particularly when self-expression is defective. Unfortunately behaviour such as restlessness ... often evokes only hostility from doctors and nurses.¹²⁹

This need to contextualise and understand behavioural problems was reminiscent of Ginzberg’s ‘attitude therapy’ over a decade earlier,¹³⁰ highlighting the slow rate of adoption of psycho-social approaches for older people.

Scandals and their aftermath

Disturbing reports about long-stay institutions had occurred for decades, highlighted in the national press¹³¹ and noted in the 1950s by social scientists such as Townsend in the UK¹³² and Goffman in the USA.¹³³ Two sets of allegations concerning UK hospitals, in 1965 and 1967, led to widespread publicity.

A letter in the *Times* in November 1965 from the founders of Aid for the Elderly in Government Institutions (AEGIS) commented on geriatric care ‘in certain mental hospitals’:

¹²⁸ Rudd, *Human Relations*, 35

¹²⁹ *Ibid.* 32

¹³⁰ Raphael Ginzberg, ‘Attitude therapy in geriatric ward psychiatry’ *Journal of the American Geriatrics Society* (1955) 3: 445-462

¹³¹ Anon. ‘Nursing home shortcomings: Committee’s proposals: registration and inspection’ *Guardian*, 20.7.1926, 12; Anon. ‘Nuffield Foundation Report’; A mental hospital nurse, ‘Patience and nurses’

¹³² Peter Townsend, *The Last Refuge* (London: Routledge and Kegan Paul, 1962) 27

¹³³ Goffman, *Asylums*

one of the evils being the practice of stripping them of their personal possessions. We now have sufficient evidence to suggest that this is widespread.

The attitude of the Ministry has merely reinforced our anxieties. In consequence, we have decided to collect evidence ... to demonstrate the need for a national investigation.¹³⁴

‘Personal possessions’ included ‘spectacles, dentures, hearing aids and other civilised necessities ... leaving them to vegetate in utter loneliness and idleness’.¹³⁵

Some of the ensuing correspondence and reports were subsequently published in *Sans Everything: a case to answer*, compiled by psychotherapist and campaigner Barbara Robb. Parallels were drawn between hospital staff and German people under the Nazi regime, who ‘were not prepared to admit what was happening in their midst’.¹³⁶ AEGIS organised a symposium, ‘Ghettos for grandparents’.¹³⁷ For a generation who remembered the Nazi incarceration of Jews and others in ghettos before deportation to concentration camps, the title alone represented discrimination and abuse. The phrase *Sans Everything* originated in Jacques’ monologue in Shakespeare’s *As You Like It*. Perhaps Robb also considered pertinent the lines immediately preceding it: ‘Last scene of all, That ends this strange eventful history’,¹³⁸ emphasising her objective of ending abuse in institutions.

The *Sans Everything* allegations included appalling lack of dignity and respect in basic care, such as nurses who

take down the patients’ knickers in the day-room and set them on commodes in full view of whoever may be there.¹³⁹

¹³⁴ Lord Strabolgi *et al.* ‘Old people in mental hospitals’ *Times*, 10.11.1965, 13

¹³⁵ Barbara Robb, ‘Preface’ xiii-xvi. In: Barbara Robb (compiler) *Sans Everything: a case to answer* (London: Nelson, 1967) xiii

¹³⁶ Michael Osbaldeston, ‘Nobody wants to know’ 13-18. In: Robb, *Sans Everything*, 14

¹³⁷ Robb, *Sans Everything*, 8-12

¹³⁸ William Shakespeare, *As You Like It* (Act 2 scene 7) lines 166-169

¹³⁹ Louisa Fenton, ‘They can not defend themselves’ 31-37. In: Robb, *Sans Everything*, 34; NHS, *Findings and Recommendations*, 19

Some of the reports were deemed to be exaggerated or unreliable,¹⁴⁰ but oral history accounts describing ‘open bed-panning’, when patients were sat on bed pans in front of other patients,¹⁴¹ or, as recently as 1981, when care home residents were sat on commodes at meal times,¹⁴² suggests similar practices were too common. The RHBs set up their investigations internally, rather than the Ministry of Health appointing independent investigators;¹⁴³ internal inquiries¹⁴⁴ implied official minimisation of the seriousness of the allegations. Despite the highly regarded individuals selected for the task, in this instance, the accused (the RHBs) appointed their own judges, ‘not the surest way of winning acceptance for the verdict’.¹⁴⁵

The *Nursing Mirror* commented defensively that *Sans Everything* highlighted ‘conditions which must inevitably lead to appalling suffering for both nurses and patients’, linking thoughtless or unkind behaviour of nurses to the unacceptable work environments commonly encountered in hospitals.¹⁴⁶ Reinforcing concerns about work conditions, nurse Doreen Norton remarked that staff choosing to work on long-stay wards must be ‘saints or fools’,¹⁴⁷ and Sheldon commented:

By and large [the hospitals] do no more than provide storage space for patients under conditions of considerable difficulty, and often unpleasantness for the nursing staff ... nurses having to fill a pint pot

¹⁴⁰ NHS, *Findings and Recommendations*, 16-17

¹⁴¹ Brooks, “‘The geriatric hospital felt like a backwater’” 2768

¹⁴² John Wattis, discussion, Mar. 2012

¹⁴³ Anon. ‘Not good enough’ *Lancet* (1968) ii: 202-203; NHS, *Findings and Recommendations*, 1

¹⁴⁴ Except in quotes, I have used ‘inquiry’ throughout this section, although primary sources use both ‘enquiry’ and ‘inquiry’.

¹⁴⁵ Anon. ‘Not good enough’ 202

¹⁴⁶ Anon. ‘Editorial’ *Nursing Mirror*, 19.7.1968, 9; Anon. ‘The *Sans Everything* enquiries’ *Nursing Mirror*, 19.7.1968, 12-13; NHS, *Findings and Recommendations*, 16-17

¹⁴⁷ Doreen Norton, *Hospitals of the Long Stay Patient: a study of their practical nursing problems & solutions* (Oxford: Pergamon, 1967) 84. Cited in: Annie Altschul ‘Methods and resources available for the training of nursing personnel’, WHO conference, Florence, 1970 (RCNA, C/305/2)

with water in order to wash excreta from a bed pan down an ordinary lavatory.¹⁴⁸

Minimising the allegations, by subjecting them to only internal inquiry, was perhaps associated with little government impetus to improve care radically. Lord Balniel, a Conservative MP, suggested an inspectorate for institutions ‘as a mark of public responsibility for those who are inarticulate in hospital’.¹⁴⁹ *Sans Everything* did not achieve that, although it helped to introduce the idea onto the policy agenda.

Sans Everything also stimulated the *News of the World*, a national Sunday newspaper with a large readership and reputation for exposing scandals, to investigate other reports of ‘hospital brutality’.¹⁵⁰ At Ely Hospital in Wales, a psychiatric hospital mainly for long-stay mental deficiency and ‘psycho-geriatric’ patients,¹⁵¹ there were allegations of cruelty, such as hitting patients hard enough to cause injury and hosing down patients in the yard rather than bathing them.¹⁵² These allegations were made by a nursing assistant to the newspaper,¹⁵³ which published an abridged version of his report alongside several others.¹⁵⁴ The ensuing investigation questioned the credibility of the informant, but concluded that, although he had ‘a grievance against the world ... he seldom, if ever, identified smoke in the absence of fire’.¹⁵⁵

Unlike the response to *Sans Everything*, for Ely Hospital, the government established an independent inquiry, chaired by Geoffrey Howe, later a

¹⁴⁸ Joseph Sheldon, *Report to the Birmingham Regional Hospital Board on its Geriatric Services* (Birmingham: RHB, 1961) quoted in Anon. ‘Hospitals for the aged’ *Lancet* (1961) ii: 88-89 88

¹⁴⁹ Lord Balniel, ‘*Sans Everything* (Reports of Inquiries) Oral answers to questions’ HC debate, 16.7.1968 <http://www.theyworkforyou.com/debates/?id=1968-07-16a.1245.1> accessed 27.6.2010

¹⁵⁰ David Roxan, ‘Heartbreak Hospitals’ *News of the World*, 20.8.1967, 7

¹⁵¹ DHSS, *Ely Hospital*, 6

¹⁵² *Ibid.* 134-135

¹⁵³ *Ibid.* 8

¹⁵⁴ Roxan, ‘Heartbreak Hospitals’; David Roxan, ‘“I saw patients being treated like dogs”’ *News of the World*, 27.9.1967, 7

¹⁵⁵ DHSS, *Ely Hospital*, 8-9

Conservative government minister. Richard Crossman, Labour Secretary of State for Social Services, noted in 1969 that Howe was ‘one of the ablest of the young Tory lawyers’.¹⁵⁶ He was an experienced Queen’s Council on the Wales and Chester Circuit and had investigated the Aberfan disaster in Wales in 1966.¹⁵⁷

Allegations at Ely were largely attributed to overcrowding and understaffing,¹⁵⁸ deficits at all levels of administration,¹⁵⁹ old fashioned nursing methods and rough handling, with staff being untutored and sometimes lacking in sympathy.¹⁶⁰

The appointment of Howe by the Labour government perhaps influenced the inquiry’s outcome. Howe wanted his entire report published. Crossman regarded the report as ‘explosive’ and feared that Howe ‘could cause trouble if sections ... were omitted’¹⁶¹ and might appear ‘on television and talk about suppression’.¹⁶² Publication of the full report was accompanied by Crossman announcing proposals for ‘regularly inspecting hospitals’ to raise standards of care.¹⁶³ Webster commented that ‘the Ely Hospital scandal ... suddenly precipitated long-stay hospitals to the head of the policy agenda’.¹⁶⁴

The combined aftermath of the *Sans Everything* and Ely Hospital inquiries, probably made the establishment of an independent inspectorate inevitable: the Ministry needed to be seen to be acting in the interest of vulnerable people. Thus the Hospital (later Health) Advisory Service (HAS), which reported

¹⁵⁶ Richard Crossman, *The Diaries of a Cabinet Minister*, Vol. 3. *Secretary of State for Social Services 1968-1970* (London: Hamilton and Cape, 1977) 408

¹⁵⁷ Geoffrey Howe, *Conflict of Loyalty* (London: Macmillan, 1994) 41-42

¹⁵⁸ DHSS, *Ely Hospital*, 128

¹⁵⁹ *Ibid.* 128-133

¹⁶⁰ *Ibid.* 123

¹⁶¹ Richard Crossman to Harold Wilson, note of phone call, 12.3.1969 (TNA, PREM 13/2803)

¹⁶² Crossman, *Diaries*, Vol. 3, 408

¹⁶³ Richard Crossman to Harold Wilson, letter, 17.3.1969 (TNA, PREM 13/2803)

¹⁶⁴ Webster, *Political History*, 80

directly to the DHSS, began to inspect long-stay hospitals in 1970.¹⁶⁵ Inspection teams were multi-disciplinary, comprising individuals temporarily seconded to the HAS and afterwards returning to their own hospitals, taking with them ideas for best practice.¹⁶⁶ The structure of the teams promoted dialogue and learning and gave new insights into the care provided for older mentally ill people.

Why did these two scandals achieve what earlier murmurings had not? With less deferential media, much publicity, and the 1960s emphasis on human rights, the public was receptive, culturally and socially. A more affluent society may have been less willing to tolerate second rate care for disadvantaged people. Some of the impact might have been due to the people making the complaints being regarded as altruistic with little to gain for themselves.

The HAS had the potential to pinpoint good and bad practice in order to achieve improvement. However, given the track record of successive governments, establishing it may have been seen as half hearted. Providing an inspectorate for care in overcrowded, dilapidated and unsuitable accommodation contrasted with the alternative of radically improving care by properly training staff and developing community and DGH facilities and services.¹⁶⁷ Early HAS reports noted little improvement in services for older people despite promises and proposals in the early 1960s.¹⁶⁸ With other national concerns towards the end of the 1960s, including rising prices, strikes and increasing unemployment,¹⁶⁹ a rapid and widespread change in provision for older people's chronic illnesses was unlikely.

¹⁶⁵ Baker, 'The Hospital Advisory Service' 16

¹⁶⁶ Alex Baker, 'Hospital Advisory Service' *BMJ* (1972) i: 176-177 177

¹⁶⁷ Samuel Last, 'Conditions in psychiatric hospitals' *Lancet* (1969) i: 884; Anthony (Tony) Whitehead, 'Conditions in psychiatric hospitals' *Lancet* (1969) i: 983

¹⁶⁸ Bridgen, 'Long term care' 521

¹⁶⁹ Dominic Sandbrook, 'Sixties Britain: introduction'
<http://www.nationalarchives.gov.uk/education/topics/sixties-britain.htm> accessed 13.3.2013

Community and epidemiological studies in the 1960s

Successive governments had not responded pragmatically to surveys in the 1940s by Sheldon and Rowntree¹⁷⁰ which identified the needs of older, community dwelling mentally unwell people and could have guided the provision of community support. Failing to define and distinguish older people's mental health needs or denying the validity of research and requesting more up to date information¹⁷¹ was, for planners, a neat method of delaying policy initiatives and financial commitment.

Following Sheldon's survey in the mid-1940s,¹⁷² in the 1950s there was a dearth of similar community health focussed reports. Townsend's study, *The Family Life of Old People*, hardly touched on mental illness.¹⁷³ Some community health surveys in the 1960s still only tagged-on old age mental illness, but others derived data from well structured epidemiological studies of randomly selected population samples.

Community and primary care surveys

Williamson surveyed people in the community (Edinburgh, 1962/3) in response to observations that some were referred to geriatric units suffering from advanced disease, neglect and poor nutrition, by GPs who stated that the patients were virtually unknown to them. This was particularly problematic because GPs were the gatekeepers to secondary care services. It raised questions of how and why observable chronic deterioration had not received timely medical or social community interventions.¹⁷⁴

In Williamson's sample, almost half of all disabilities and most depression and dementia were unknown to the GP.¹⁷⁵ Self reporting of ailments, which might

¹⁷⁰ Sheldon, *Social Medicine*; Rowntree, *Old People*

¹⁷¹ Phillips Report, 83

¹⁷² Sheldon, *Social Medicine*

¹⁷³ Townsend, *Family Life*, 222-223

¹⁷⁴ James Williamson, IH Stokoe, S Gray, M Fisher, 'Old people at home: their unreported needs' *Lancet* (1964) i: 1117-1120 1117

¹⁷⁵ *Ibid.* 1118

be readily treatable in the early stages, by older people to their GPs, was inadequate, possibly because they had grown up without a NHS, or they attributed symptoms to old age rather than treatable illness.¹⁷⁶ Williamson vividly outlined additional reasons why morbidity might be unknown to the GP, reiterating long recognised but neglected factors, including medical education and the complex nature of old age illness:

we are still producing ... doctors whose orientation is towards the acute illness and preferably an exotic illness and preferably almost unbelievably rare, in an otherwise splendidly healthy human being ... The second reason is that doctors do not appreciate how common are multiple lesions in the aged.

The third ... is the problem of dementia ... The old person who is dementing is just not able to understand the nature of his condition. He has little insight into his plight and, even if he has, he may not have the wit remaining to call in his doctor or go to see his doctor ... I am convinced that dementia is possibly the greatest single factor we have to worry about in dealing with problems of old people in our society.¹⁷⁷

Other studies of primary care paid less attention to mental illness in old age; two focussed just on physical health,¹⁷⁸ and another, which investigated functional mental illness, excluded dementia.¹⁷⁹ The latter, however, importantly, included people over 65 indicating that some functional illness was appropriately distinguished from dementia in that age group.

In Swansea, South Wales, (1960-62) a random sample was drawn from the electoral register to study the mental health of people over 65.¹⁸⁰ Appropriately, a psychiatrist undertook the psychiatric assessments using the best available recently validated tools. However, these new tools had drawbacks, probably not fully recognised at the time. For example, they focussed on short term

¹⁷⁶ *Ibid.* 1120

¹⁷⁷ James Williamson, 'Screening examinations in old age' *Journal of the College of General Practitioners (JCGP)* (1966) 11: Supplement 1: 89-93 91-92

¹⁷⁸ G Carey, 'Undisclosed morbidity in persons aged over 70 in a Belfast general practice' *JCGP* (1967) 14: Supplement 2: 43-52; C Burns, 'Geriatric care in general practice A medicosocial survey of 391 patients undertaken by health visitors' *JCGP* (1969) 18: 287-296

¹⁷⁹ B Cooper, A Brown, G Kalton, 'A pilot study of psychiatric morbidity in general practice' *JCGP* (1962) 5: 590-602

¹⁸⁰ P Parsons, 'Mental health of Swansea's old folk' *British Journal of Preventive and Social Medicine (BJPSM)* (1965) 19: 43-47

memory loss, largely ignoring other cognitive domains,¹⁸¹ so risking underestimating the prevalence of dementia. As in previous studies, definitions were loosely and locally defined making comparisons with other studies difficult, for example, the term ‘demented’ was only used to indicate those sufficiently cognitively impaired to render self-care impossible. The study identified 10 (4%) as demented, plus 72 (32%) with some memory loss.¹⁸² Nine to ten *per cent* were ‘markedly handicapped’ by a psychiatric disorder. In summary, almost half had some psychiatric disorder, and, although most with dementia were known to the GPs (in contrast to Williamson’s study), most with depression, or a history of it, were not.¹⁸³ If disorders, especially depression, remained undetected in primary care, ameliorable distressing symptoms would not be treated.

The importance of accurate diagnosis, based on Roth’s categories of mental illness in older people, was reiterated in the 1960s in journals likely to be read by GPs¹⁸⁴ and on courses on psychogeriatrics designed for them.¹⁸⁵ However, at a seminar for GPs in 1969, some still did not believe that depression and schizophrenia were separate from organic conditions in old age.¹⁸⁶ Interest was apparent, knowledge less so, but GPs fortunately wanted more training in psychiatry, including about dementia.¹⁸⁷

Older people were, *pro rata*, referred for specialist psychiatric opinions less than younger people.¹⁸⁸ Some GPs regarded referral of ‘elderly confused patients’ to psychiatrists or geriatricians as ‘a waste of time or unkind to their

¹⁸¹ J Inglis, ‘A paired-associate learning test for use with elderly psychiatric patients’ *JMS* (1959) 105: 440-443

¹⁸² Parsons, ‘Swansea’ 45

¹⁸³ *Ibid.* 47

¹⁸⁴ e.g. Felix Post, ‘Management of senile psychiatric disorders’ *BMJ* (1968) 4: 627-630; Enoch, ‘Elderly disturbed’

¹⁸⁵ Morgannwg Hospital Management Committee, ‘Psychogeriatrics and related problems’ (1963) (WL/PP/RFK/C.8)

¹⁸⁶ Klaus Bergmann, ‘Mental aspects of cerebrovascular disease’ *JCGP* (1969) 18: 84 Supplement 1: 7-14. Discussion, 13-14

¹⁸⁷ RCGP, *Education in Psychology and Psychiatry* (London: RCGP, 1967) 29

¹⁸⁸ Philip Hopkins, Brian Cooper, ‘Psychiatric referral from a general practice’ *BJPsych* (1969) 115: 1163-1174

patients'.¹⁸⁹ Rates of referral were likely to be influenced not only by the GP's recognition of the disorders, but also by whether the GP experienced the local specialist's opinion and the staff in the clinical team as helpful.

The Newcastle study

Research about old age mental disorders in the community by Kay and Roth's team contributed significantly to understanding their epidemiology and the services required.¹⁹⁰ There were methodological limitations, such as identifying the boundaries between normal ageing and pathological syndromes, and the limitations of cross-sectional studies for distinguishing 'associated' and 'aetiological' factors, but the data obtained were the best available and conclusions were convincing.

They drew their sample from the electoral register for the community and from a census of institutionalised patients, as 'mentally ill subjects may well have been omitted from the electoral register',¹⁹¹ an indictment of their status. Prevalence rates of mental disorders in over 65s were higher in the community than in institutions: 246 per 1000 and 17 per 1000 respectively (excluding those with chronic schizophrenia, many of whom entered institutional care earlier in adult life),¹⁹² rates consistent with earlier and later studies.¹⁹³ The finding of high community prevalence was similar to Townsend's observations on physical incapacity; most bedfast people lived in private households rather than in institutions.¹⁹⁴ These data reinforced the observation that institutionalisation

¹⁸⁹ Alex Sampey, 'Trends in the mental health services' *JCGP* (1962) 5: 302-304 303-304

¹⁹⁰ David Kay, Pamela Beamish, Martin Roth, 'Old age mental disorders in Newcastle upon Tyne: A study of prevalence' *BJPsych* (1964) 110: 146-158; David Kay, Pamela Beamish, Martin Roth, 'Old age mental disorders in Newcastle upon Tyne: a study of possible social and medical causes' *BJPsych* (1964) 110: 668-682; David Kay, Pamela Beamish, Martin Roth, 'Some medical and social characteristics of elderly people under state care' *Sociological Review Monograph* (1962) 5: 173-193; David Kay *et al* 'Mental illness and hospital usage in the elderly: a random sample followed up' *Comprehensive Psychiatry* (1970) 11: 26-35

¹⁹¹ Kay, 'Study of prevalence' 146, 147

¹⁹² *Ibid.* 152

¹⁹³ Department of Health, *National Service Framework for Older People* (London: DoH, 2001) 99, 103

¹⁹⁴ Townsend, *Last Refuge*, 281

of older people was not solely determined by illness and disability but was intertwined with social factors.

The Newcastle results were characteristically presented with great clarity. They suggested community support to attempt to avoid admission to hospital and alleviate the stresses on carers. They placed the onus on local authorities: 'the aged have three main needs capable of being met by political and social planning': local authority health and welfare services to complement the work of the general practitioner, well designed local housing schemes, and appropriate social and recreational facilities. They also recommended registers of vulnerable older people to facilitate assessments by health and social services and to help detect mental disorders at an early stage.¹⁹⁵

The Newcastle study was methodologically the most robust, largely because of the sampling procedure, with wide implications for its findings. Results of this study, and the other community and primary care surveys, were published in peer reviewed general medical, psychiatric and public health journals which would have been readily accessible in medical libraries. Despite the evidence, in 1969, John Brothwood, Senior PMO at the DHSS, asked for more:

The services for the aged cannot be planned rationally at a local level nor meaningful policy formulated centrally unless basic data are available about the numbers of people at risk and the incidence and prevalence of problems.¹⁹⁶

This was akin to the request in the Phillips Report in 1954.¹⁹⁷ The reasons for the request are unclear, but the DHSS seemed surprisingly ignorant of published epidemiological information, or they ignored it. Reasons for inactivity are difficult to identify, but the low value of older people in society, especially if needing support, and a lack of responsibility towards their welfare, may have contributed.

¹⁹⁵ Kay, 'Social and medical causes' 681

¹⁹⁶ Brothwood, 'Organisation' 99

¹⁹⁷ Phillips Report, 83

Teaching and other research

In the 1960s, psychogeriatrics passed unrecognised as a subject worthy of clinical teaching at university medical schools, despite clinical need, research and increasing knowledge. Most academic psychiatrists showed little interest in older people and geriatricians were only just gaining a foothold in the universities. Medical schools still focused on acute illnesses, although whether they could be treated effectively was not a criterion for teaching or academic interest. For example, there was little effective clinical treatment for any mental illness when Edward Mapother was appointed first professor of psychiatry at the Maudsley Hospital in 1936.¹⁹⁸ That, in turn, was long after psychiatry was recognised as an academic discipline in Germany.

New psychogeriatric research was discussed at a World Psychiatric Association (WPA) symposium in London in 1965. The WPA was established in 1961 and this was their first regional meeting on a specific subject.¹⁹⁹ The symposium spanned three days. This contrasted with earlier international gerontology conferences, where mental disorders were generally allocated a single session,²⁰⁰ and suggested an expanding knowledge base and increasing interest. Contributors included Post, Robinson, Stengel, members of the Newcastle team, and Nick Corsellis.²⁰¹ The event made a significant impact on delegates. Klaus Bergmann attended as a junior doctor; 43 years later he had vivid memories, such as about Post

who impressed me enormously, and it was the first time I ever heard him or met him ... presenting his very careful study of paranoid illnesses, their treatment, their liability to relapse without treatment and the outcome of his series of follow-ups.²⁰²

¹⁹⁸ Edgar Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley' *Medical History* (2003) Supplement: 22: 3-38 19

¹⁹⁹ WPA, *Psychiatric Disorders*, 1

²⁰⁰ IAG, *Modern World*, 393

²⁰¹ WPA, *Psychiatric Disorders*, contents page

²⁰² Felix Post, 'Diagnosis and management of paranoid syndromes' 108-120. In: WPA, *Psychiatric Disorders*; Bergmann, 'Witness' 40

This thesis does not permit space to comment on the entire conference. However, the neuropathological research by Corsellis at Runwell Hospital, Essex²⁰³ needs specific mention. It had important implications for accurately understanding, and therefore changing attitudes towards, ‘senile dementia’. Corsellis’s post-mortem study of 300 brains of former in-patients concluded that there was no difference in neuropathology between Alzheimer’s (‘pre-senile’) and senile dementia.²⁰⁴ This contradicted established understanding, based on Kraepelin’s teaching, that the two conditions were pathologically distinct.²⁰⁵ Corsellis’s evidence placed the single disorder in the realms of commonly occurring unexplained pathology which warranted research and clinical attention. Nevertheless, his message was only slowly taken on board. Medical students in the late 1960s recollect being taught Kraepelin’s view,²⁰⁶ and a historical analysis commented that, until 1975, the literature remained inaccurate, ‘replete with arguments for the distinctiveness of Alzheimer’s disease and senile dementia’.²⁰⁷

Another major symposium, organised by the RMPA, *Recent Developments in Psychogeriatrics*, took place in 1969.²⁰⁸ Notably, for the first time, the term ‘psychogeriatrics’ appeared in the title; it was beginning to acquire a meaning, and, according to Macmillan, was ‘becoming generally accepted’.²⁰⁹ Six of ten presentations were given by researchers already referred to in this study, including Ferguson Anderson, Bergmann, Brothwood, Lishman, Post and

²⁰³ JAN (Nick) Corsellis, ‘Cerebral degeneration and the mental disorders of later life’ 292-307. In: WPA, *Psychiatric Disorders*, 292

²⁰⁴ Corsellis, *Mental Illness and the Ageing Brain*, 54

²⁰⁵ Alois Alzheimer, ‘Über eigenartige Krankheitsfälle des späteren Alters’ (1911) Translated into English; ‘On certain peculiar diseases of old age’ *History of Psychiatry* (1991) 2: 74-101 75-76; German Berrios, ‘Alzheimer’s disease: a conceptual history’ *IJGP* (1990) 5: 355-365 360, 363

²⁰⁶ John Wattis, e-mail, 2012

²⁰⁷ Myrna Schwartz, Jacqueline Stark, ‘The distinction between Alzheimer’s disease and senile dementia: historical considerations’ *Journal of the History of the Neurosciences* (1992) 1: 169-187 178

²⁰⁸ Kay and Walk (ed.) *Recent Developments*

²⁰⁹ Duncan Macmillan, ‘Problems of a geriatric mental health service’ *BJPsych* (1967) 113: 175-181 175

Roth.²¹⁰ Their contributions are discussed in their appropriate contexts in other parts of this thesis.

At the Bethlem-Maudsley: Felix Post's research, leadership and teaching

Post carried out two major clinical 'follow-up' studies, each comprising around 100 older patients followed for up to eight years. They fitted with Bethlem-Maudsley research priorities; the hospital had a 'follow-up office' to assist with organising these studies.²¹¹ *The Significance of Affective Symptoms in Old Age* was published as one of the esteemed 'Maudsley Monograph' series in 1962.²¹² The other was about 'persistent persecutory states'; terminology was still only loosely defined, but this was roughly synonymous with schizophrenia in old age or Roth's 'late paraphrenia'.²¹³ Post's preliminary reports were unfortunately not published in influential journals,²¹⁴ but his subsequent monographs confirmed the enormous benefit of interventions such as medication and ECT.²¹⁵ Despite its obvious importance for patients, policy makers, the NHS and social services, Post's research appeared to be undervalued by the psychiatric establishment. It was virtually ignored by academic psychiatrists in their profile of research carried out at the Maudsley Hospital and Institute of Psychiatry between 1945 and 1966.²¹⁶

Post's monograph, *The Clinical Psychiatry of Late Life*,²¹⁷ like Rudd's textbook,²¹⁸ was small, concise, relevant, compassionate and highly readable. It was the first text book in Britain to emphasise an evidence based approach to

²¹⁰ Kay and Walk (ed.) *Recent Developments*, contents page

²¹¹ Bethlem-Maudsley, Sub-committee to consider arrangements for the follow-up office, 3.12.1954, MCD75/54 (BMHA)

²¹² Post, *Affective Symptoms*

²¹³ Post, *Persistent Persecutory States*, 7-8, 11

²¹⁴ e.g. Felix Post, 'The significance of affective symptoms in old age' 227-230. In: IAG, *Fourth Congress*; Post, 'Geriatric unit'

²¹⁵ Post, *Affective Symptoms*; Post, *Persecutory States*

²¹⁶ Michael Shepherd, David Davies (ed.) *Studies in Psychiatry – a survey of work carried out in the Department of Psychiatry of the Institute of Psychiatry under the chairmanship of Sir Aubrey Lewis 1945-66* (London: OUP, 1968)

²¹⁷ Post, *Clinical Psychiatry of Late Life*

²¹⁸ Rudd, *Human Relations*

active psychiatric treatment of older mentally ill people. It contrasted with Oscar Kaplan's earlier text book in the USA which was larger and more theoretical with less focus on clinical interventions.²¹⁹ Post's book guided the reader, with an up-to-date multi-disciplinary, practical, helpfully dogmatic approach, at a time when sound guidelines on clinical practice were lacking. His book expressed his clinical methodology: a dedicated ward, a multi-disciplinary team, positive expectations, accurate diagnosis and active treatment.

The message from Post's studies of clinical effectiveness, especially when combined with Roth's classification,²²⁰ was as revolutionary as Warren's reports two decades earlier, yet it lacked impact on psychiatric hospital policy and practice. Searches at the National Archives revealed no clues about whether the Ministry of Health was aware of, or understood, the implications of Post's work. Lewis could probably have alerted the Ministry if he had wished. However, his priorities were influenced by the Bethlem-Maudsley acute treatment ethos and he had ignored the Ministry's recommendations about older people in 1950.²²¹ Lewis's responses, combined with the Bethlem-Maudsley's elitist reputation, might have undermined its credibility at the Ministry and among psychiatrists elsewhere, who, given widespread unconstructive attitudes towards mentally ill older people, might have regarded its teachings as impossible to emulate or inapplicable to older people in their psychiatric hospitals.

During the 1950s and 1960s Post repeatedly tried to improve conditions for his patients, an immense challenge for a lone psychiatrist advocating for older people. The Bethlem-Maudsley's prioritisation of younger people and ambivalence towards older people persisted, and included proposals to reduce

²¹⁹ Oscar Kaplan (ed.) *Mental Disorders in Late Life* (Stanford: Stanford University Press, 1945 and 1956)

²²⁰ Roth, 'Natural history'

²²¹ MoH, *Care of the Aged* ; MoH, *Treatment of the Elderly*

beds in the Geriatric Unit and re-designate them to other departments.²²² Lewis's influence at the Bethlem-Maudsley remained strong until he retired in 1966.²²³ His responsibilities as head of a post-graduate psychiatric teaching hospital perhaps unavoidably distracted him from his earlier interest in older people.

Post admitted being relatively protected from the difficulties of the majority of psychiatric hospitals and ignorant of central government policies and proposals.²²⁴ He did not try to 'sell' his treatment model. Support from the Ministry and a cultural and organisational shift similar to that identified in the 'Worthing experiment'²²⁵ would be required for active treatment and rehabilitation for older people to become routine practice nationally. If seeds of change were germinating within the medical profession, politically savvy clinical leaders were essential to promote their ideas at the Ministry to bring about widespread high quality services. Post, Robinson and Macmillan were not in that category. They were dedicated clinicians who did not seek publicity for themselves or their work. Post and Robinson modestly attributed many of their achievements to others.²²⁶ Post's enthusiasm, research, clinical skills and 'marvellous phenomenological teaching – there had never been anything like it – it was quite exhilarating'²²⁷ were an inspiration to junior doctors.²²⁸ However, meticulous follow-up studies and personal inspiration were not a recipe for rapidly creating widespread services, although they provided firm foundations.

²²² Bethlem-Maudsley, Rehabilitation Committee, 17.1.1966, RHD1/66, MCD2/66, RHM2/66; Medical Committee, 26.1.1967, 'In-patient addiction unit' GPD16/67, MCD14/67 (BMHA)

²²³ Series, 'Lewis'

²²⁴ Post (BLSA)

²²⁵ Carse, 'District' 40

²²⁶ Post, 'In the beginning'; Robinson, 'Witness' 10

²²⁷ Tom Arie, interview by author (2004)

²²⁸ Tom Arie, 'Remembering Felix' *Psychiatric Bulletin* (2002) 26: 199-200

Places and people: clinical units in the 1960s

Space does not permit detailed inclusion of the new units emerging in the 1960s, such as at Claybury Hospital (Woodford),²²⁹ St Nicholas and the Brighton Clinic (Newcastle upon Tyne), St Francis (Brighton),²³⁰ the Hallett Clinic (Exeter)²³¹ and at Redruth (Cornwall) in the same locality as Andrews' geriatric initiative which started in the 1940s.²³² Others have already been mentioned, such as in Edinburgh²³³ and Nottingham,²³⁴ and at Crichton Royal and the Bethlem-Maudsley.

Clinicians leading the new units, without government directives, were optimistic and creative, observing the benefits of their interventions. Each unit developed differently, usually based on an individual's ideals, perceived local needs, existing institutional facilities, designated catchment areas, waiting lists and medical superintendents' expectations. They were all experimental. Some aspired to be comprehensive like Robinson's, others less so. There was no typical service.

Not all the mid-1960s innovations had the desired outcomes. For example, a 'psychogeriatric area' was opened in 1966 at Fulbourn Hospital, Cambridge. Initially old age care improved, but the service became overloaded and morale fell. It did not pick up again until a dedicated consultant (Peter Brook) was appointed in 1979.²³⁵ Perhaps the creation of a psychogeriatric 'area' paid lip service to emerging ideas, giving the impression that provision had been made but without providing dedicated leadership or financial commitment. Some schemes maintained their high profile. Others may have fallen foul of

²²⁹ Brice Pitt, interview by author (2004)

²³⁰ Klaus Bergmann, interview by author (2004)

²³¹ Gordon Langley *et al.* 'The Exe Vale joint psycho-geriatric assessment unit (Hallett Clinic)' *Age Ageing* (1975) 4: 125-128

²³² J Donovan, I Williams, T Wilson, 'A fully integrated psychogeriatric service' 113-125. In: *Recent Developments* ed. Kay and Walk; Andrews, 'Early days'

²³³ Fish and Williamson, 'Delirium unit'

²³⁴ Morton, 'Joint assessment'

²³⁵ David Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London: Process Press, 1996) 232

economic priorities, change of leadership or fashion,²³⁶ but negative outcomes, unless media-worthy, were unlikely to be recorded outside individual hospital management committees.

The indifference of many psychiatrists towards working with older people might have allowed interested psychiatrists *carte blanche* to work with them. However, such freedom was moderated by complex interactions inside and outside the profession. Bed occupancy, for example, might be important to the nursing hierarchy; at Goodmayes²³⁷ and Warlingham Park hospitals senior administrative and nursing staff

had their salaries weighted by the number of beds standing so when a bed was declared redundant by the medical Staff, it would be dismantled and left in a corner of the dormitory in order that it might be annotated as still standing.²³⁸

At Claybury Hospital in 1966 some consultants wanted to keep their older patients with treatable conditions, but hand over those thought to be incurable.²³⁹ Others were unwilling to relinquish their caseload of older people perceived as needing little medical input. Conflict also arose over domiciliary visits (DVs), which were requested by GPs and were most likely to be required by older frail people. DVs attracted fees paid in addition to the standard consultant salary, which were regarded as an unfair financial advantage to the new psychogeriatricians.²⁴⁰ Often, however, the psychogeriatricians did not claim the fees, regarding home assessments as a routine component of good practice.²⁴¹ Also, colleagues of equal status do not like to be told by others that they can do the job better: challenges to professional skills were linked with

²³⁶ D Prinsley, 'Psychogeriatric ward for mentally disturbed elderly patients' *BMJ* (1973) iii: 574-577

²³⁷ Arie (BLSA)

²³⁸ Carrick McDonald, 'A rehabilitation programme for chronic psychogeriatric patients' (1977) 3 (PJ)

²³⁹ Pitt, interview by author, 2006

²⁴⁰ *Ibid.*; Michael Denham, autobiographical note, 'Witness' 98-99, 98

²⁴¹ Garry Blessed, letter, 11.6.2013

ambivalence towards emerging new specialties,²⁴² risking undermining developments.

Sometimes colleagues were unhelpful to the new psychogeriatricians, as Bill Boyd recalled:

I went to see the geriatrician ... and he agreed to see me, put it that way. And he sat behind his desk and smoked his pipe and there was a lot of smoke coming out of it. He wondered aloud whether they could find any patients for me ... He was not in the business of co-operation.²⁴³

This sort of attitude may have been due to lack of interest or understanding, or not taking psychogeriatricians seriously. Challenging such attitudes required determination, inspiration, perseverance, a thick skin and emotional strength to cope with professional isolation.²⁴⁴

The small nucleus of new psychogeriatricians was in a state of flux which might have given the DHSS the impression that specialising in psychogeriatrics was unworkable.²⁴⁵ Brice Pitt moved from psychogeriatrics at Claybury into general psychiatry at a new DGH, a prized post, returning to psychogeriatrics at the London Hospital in 1971.²⁴⁶ Klaus Bergmann trained in psychogeriatrics in Newcastle, then moved to Brighton. He remained there only three years (1966-69) with an excessive work load before returning to Newcastle at Roth's invitation.²⁴⁷ Anthony Whitehead moved from Severall's Hospital (see below) to Manchester then Brighton around the end of the 1960s.²⁴⁸ Robinson moved from Crichton Royal to Edinburgh in 1971.²⁴⁹ Another psychogeriatrician, Michael White, who moved from Aylesbury to Hereford a few years later,

²⁴² Rosen, *Specialisation*, 63, 67; Granshaw, *St Marks*, 428

²⁴³ Boyd, 'Witness' 34

²⁴⁴ Brice Pitt, 'Witness' 20

²⁴⁵ Tom Arie, discussion, 2013

²⁴⁶ Pitt (BLSA)

²⁴⁷ Bergmann, interview by author, 2004

²⁴⁸ David Jolley, 'John Anthony Whitehead' *Psychiatric Bulletin* (2003) 27: 478

²⁴⁹ Ronald (Sam) Robinson, unpublished autobiographical note, 2009

offered an explanation for changing location, reflecting tensions between management and clinicians:

quite a few of the first wave of Psychogeriatricians have made a move to another post ... Perhaps to some of us the attraction in the work resembles the lives of the Norsemen – there is a thrill in sailing up some administrative backwater and creating mayhem. If so, then once a new service becomes accepted ... life begins to get dull; accordingly one day we return to our longboats – to the heartfelt relief of the locals – and head for new places to conquer. The metaphor is not wholly accurate – life would be easier could we burn down the occasional administrative HQ and put its occupants to the sword!²⁵⁰

An in-depth case study of select psychogeriatric units enables successes and problems to be explored to shed further light on the subject, though selection also risks bias by excluding other noteworthy services. I will examine two well documented and contrasting schemes which exemplify innovation, at Severalls Hospital, Colchester, and Goodmayes Hospital, Ilford. Severalls was semi-rural. The psychogeriatric assessment unit started in 1961. Goodmayes was suburban. Its psychogeriatric unit started in 1969 and was a hub of research and evaluation from the beginning. In both, the leadership were dedicated and had the skills to write about their schemes and inspire others, but in other ways outcomes differed.

Severalls

Severalls' medical superintendent, Russell Barton, was a visionary psychiatrist widely known for his humane, innovative and dynamic approach to patients and for his confrontational dealings with management and colleagues.²⁵¹ His book, *Institutional Neurosis*, highlighted the harm that could be done by institutionalisation.²⁵²

²⁵⁰ DMD (Michael) White, 'Moving on' *SPOA Newsletter* (1981) 3: 12-14 12

²⁵¹ Diana Gittins, *Madness in its Place: narratives of Severalls Hospital 1913-1997* (London: Routledge, 1998) 67-89

²⁵² Barton, *Institutional Neurosis*

Barton modelled his new scheme for older people on Robinson's at Crichton Royal.²⁵³ It comprised assessment, treatment, rehabilitation and community services, including a boarding out scheme to enable discharge for those with no home to return to. Staff also provided a rota for an out-reach ambulance to evaluate patients in the community, deal with minor emergencies and prevent hospital admission.²⁵⁴ Barton's charismatic ethos of social responsibility inspired others. David Jolley, later consultant psychogeriatrician in Manchester then professor in Wolverhampton, wrote: 'Russell Barton was a hero. A huge amount of good has followed from his initiatives; very little of it knowing the source of its inspiration'.²⁵⁵ Jolley also enthused about Barton's assistant, Anthony (Tony) Whitehead:

Wherever he went, others were moved to do more than they had ever imagined possible ...

His natural optimism and turn of phrase were a tonic to many. 'Where there's depression,' he would smile 'there's hope!'²⁵⁶

Whitehead's paper about Severalls in the *Lancet* in 1965 reached the attention of the Ministry of Health.²⁵⁷ It provided substantial evidence for psychogeriatric service effectiveness. In particular, during a 16 month period, total in-patient numbers fell from 374 to 296 despite more (339 to 407) shorter admissions for assessment and treatment.²⁵⁸ Drs Tooth and Winner planned a meeting to discuss psychogeriatric services. They enthusiastically suggested inviting Barton and Whitehead.²⁵⁹ However, the minutes record neither their attendance nor apologies, so it is unlikely they were invited. Perhaps that was due to Barton's volatile temperament; Tooth referred to him as 'the CMO's tiger'.²⁶⁰ They seemed to shy away from involving him. Two other eminent

²⁵³ Barton, interviewer, Gittins, 14

²⁵⁴ Anthony (Tony) Whitehead, *In the Service of Old Age: the welfare of psychogeriatric patients* (Harmondsworth: Penguin Books, 1970) 91-102

²⁵⁵ David Jolley, 'Remembering Russell Barton' *Psychiatric Bulletin* (2003) 27: 233-234 234

²⁵⁶ Jolley, 'Whitehead'

²⁵⁷ Anthony (Tony) Whitehead, 'A comprehensive psychogeriatric service' *Lancet* (1965) ii: 583-586 (TNA, MH 160/486)

²⁵⁸ Whitehead, 'Comprehensive psychogeriatric service' 586

²⁵⁹ Probably from Dr Tooth to Dr Boucher, (MoH), memo, 4.10.1965 (TNA, MH 160/486)

²⁶⁰ Dr Tooth, memo, 30.9.1965 (TNA, MH 160/486)

and experienced advocates sympathetic to the psychogeriatric cause participated, Norman Exton-Smith, a geriatrician²⁶¹ and Macmillan. Macmillan was on the verge of retiring,²⁶² and Exton-Smith did not have the creativity and dedication specifically concerning psychogeriatric services which Whitehead and Barton had shown.

At their meeting, Tooth commented on the urgent need to improve care of older people in psychiatric hospitals.²⁶³ Valid suggestions were made about joint psychiatric-geriatric assessment, appointing geriatricians to work in psychiatric hospitals and better training about psychiatry for nurses on geriatric wards. A second meeting was planned²⁶⁴ but no further details have been traced at the National Archives.

In 1969, despite its successes and inspiration to local staff, the psychogeriatric unit was not wholeheartedly supported by the DHSS. Brothwood commented:

While this sort of development is undoubtedly fulfilling a local need, it is open to question whether it should be taken up as a pattern for services in other areas.²⁶⁵

Brothwood then commented on difficulties of staffing large psychiatric hospitals:

some who take up psychiatric nursing as a career are not prepared to spend their professional lives caring for the physical needs of the elderly patient. In short, an excessive proportion of the elderly in a hospital may affect nurse recruitment adversely.²⁶⁶

These remarks were problematic. In particular, Brothwood did not seem to understand Whitehead and Barton's interventionalist model of psychogeriatrics

²⁶¹ RE Irvine, 'Smith, Arthur Norman Exton- (1920-1990)', *ODNB*, OUP, 2004; <http://www.oxforddnb.com/view/article/57334> accessed 10.4.2013

²⁶² HF, 'Macmillan'

²⁶³ MoH, minutes: 'Provision of psychiatric services for the elderly' 12.11.1965, 1 (TNA, MH 160/486)

²⁶⁴ *Ibid.* 3

²⁶⁵ Brothwood, 'Organisation' 110

²⁶⁶ *Ibid.* 110

or that staff, particularly nurses, might be enthused as they were at Severalls.²⁶⁷ This was unfortunate in view of Brothwood's seniority at the DHSS. His view of Severalls may have been coloured by Barton's reputation as a 'maverick ... who thrived on controversy',²⁶⁸ but it also suggested that the DHSS had no clear plans for mentally ill older people despite the *Sans Everything* and Ely Hospital inquiry reports.

In 1970 Whitehead described the achievements of their service. They had overcome deeply embedded unhelpful attitudes of staff towards older people. These included lack of interest, infantilising approaches to dependency, such as nurses referring to those in cot-beds as 'babies', and harsh undignified criticism of patients e.g. 'You filthy old thing. I shall smack you if you do that again'.²⁶⁹ Their service aimed to be 'an enlightened institution' treating older people like adults, letting them have a say in their care, and acknowledging that 'doctors and nurses do not necessarily know best'.²⁷⁰ Society's new values about autonomy and individuality were not universally adopted in the 1960s. Whitehead's emphasis that patients might have valuable opinions about their own care suggests that health and welfare services, at least for older people, were far from achieving this ideal.

By 1970, Barton had emigrated to the USA²⁷¹ and Whitehead had left Severalls.²⁷² Severalls 'reverted to a situation of poor leadership'.²⁷³ The success of the Severalls' scheme was linked to its named leaders. As with Macmillan in Nottingham and Freudenberg at the Ministry, when the innovators departed, momentum ceased. The Severalls scheme did not transform interest in older people's mental health either locally or on a national policy level.

²⁶⁷ Whitehead, *Service of Old Age*, 95

²⁶⁸ Henry Rollin, 'Russell William Andrew Charles Barton' *Psychiatric Bulletin* (2003) 27: 35

²⁶⁹ Whitehead, *Service of Old Age*, 28

²⁷⁰ *Ibid.* 35

²⁷¹ Gittins, *Madness*, 89

²⁷² Jolley, 'Whitehead'

²⁷³ Gittins, *Madness*, 92

Goodmayes

Tom Arie had reviewed *Sans Everything* for the *Lancet*. The existence of such ‘wretched situations’²⁷⁴ inspired him to apply for a consultant psychiatrist vacancy at Goodmayes Hospital specifically to work with mentally ill older people.²⁷⁵ Having worked in both psychiatry and social medicine, Arie had become

terribly interested in ... providing services for unglamorous but necessary parts of the health service ... what made them tick and how you made them interesting and attractive to staff and how you provided good quality care.²⁷⁶

In 1969, eight years after the Severalls scheme commenced, the Goodmayes ‘psychiatric service for old people’ was created.

Arie led a team with low hierarchical structure. He aimed to provide a flexible service with open and effective communication and collaboration, and ‘We should take responsibility for every solution which we formulated, and always be ready to think again’. Clinical interventions were based on prompt availability of assessments, preferably in the patient’s home.²⁷⁷ Initial assessments were usually by a consultant: the most skilled resource was put up front to ensure the most efficient use of other services.²⁷⁸ Able staff were ‘eager to work on the unit’.²⁷⁹ Arie, like Barton, was a charismatic leader. Unlike him, Arie erred on the side of cautious innovation, avoiding unnecessary conflict.

²⁷⁴ Anon. ‘The elderly in hospital’ *Lancet* (1967) ii: 85-86 86 (Identified by Arie as his work)

²⁷⁵ Arie, e-mail, 26.4.2009

²⁷⁶ Arie (BLSA)

²⁷⁷ Tom Arie, ‘The first year of the Goodmayes psychiatric service for old people’ *Lancet* (1970) ii: 1179-1182 1179

²⁷⁸ David Jolley, e-mail, Nov. 2012

²⁷⁹ Arie, ‘The first year’ 1181

Arie's theories were put to the test with enormous enthusiasm and inspiration to his team. One of his junior doctors, Nori Graham, later consultant psychogeriatrician at the Royal Free Hospital, recalled:

He made it so exciting, he even made the blood test results exciting ... I saw people getting better, I saw people being discharged, I saw us starting to empty those wards – how fortunate I was.²⁸⁰

In the first year, admissions and discharges increased, deaths declined and 40 beds were vacated out of 350 in his seven long-stay wards.²⁸¹ Echoing Warren's early experience at West Middlesex,²⁸² Arie later reflected:

I was increasing the turnover. I was preventing chronicity, I was sorting out people in long-stay care who didn't need it and greatly improving the environment.²⁸³ (Fig 12)

²⁸⁰ Nori Graham, 'Witness' 45

²⁸¹ Arie, 'The first year' 1179, 1180

²⁸² Warren, 'Chronic sick'

²⁸³ Arie (BLSA)

Fig 12. 'Improving the environment': a psychogeriatric ward at Goodmayes, 1969 and 1970

1969



Note beds in middle of ward, no lockers, no curtains, linoleum floors.
Plastic pot plant (far left foreground).

Source: Tom Arie

1970



Note fewer beds, lockers, curtains, new flooring.

Source: Tom Arie

Arie reported the first year of the Goodmayes service to the Keppel Club, ‘a think tank with an influence beyond its size’.²⁸⁴ The club included eminent social scientists such as Richard Titmuss and Peter Townsend, and physicians such as George Godber, CMO, and Jerry Morris, professor of social medicine, with whom Arie had worked. Concerning his presentation about Goodmayes, Arie recollected:

Notes and postcards after the meeting were full of encouragement. Sir George Godber was not present but read the minutes and sent his chief psychiatrist, Arthur Oldham, to take a look at Goodmayes – thereby establishing the beginning of the links with the Department of Health.²⁸⁵

Godber (1908-2009) was later acknowledged to have ‘exercised an influence over health policy that remains unmatched’ by any other holder of that post.²⁸⁶ He was CMO from 1960-73, in the wake of the MHA 1959 and the *Hospital Plan*, making him ideally placed to improve many services, including mental health. According to Geoffrey Rivett, a physician and historian of the NHS, Godber was also

always on the look out for young people with talent. He would identify people with good ideas and ensure that they were placed on committees normally inhabited by very senior people. You do not get tomorrow's policies, he said, by speaking to yesterday's people.²⁸⁷

There were similarities between Arie’s psychogeriatric service catching Godber’s attention and why Warren’s geriatric service caught the attention of the Ministry of Health a quarter of a century earlier. Warren and Arie both succeeded in vacating hospital beds by improving the health of patients, a humane objective, but perhaps more appreciated by the authorities as a means of reducing health service costs and alleviating overcrowding. Both evaluated and wrote up their schemes and received visits from the Ministry/DHSS. For

²⁸⁴ John Fry, ‘The Keppel Club 1952-74: lessons from the past for the future’ *BMJ* (1991) 303: 1596-1597 1596

²⁸⁵ *Ibid.* 1597

²⁸⁶ Douglas Black, ‘Sir George Godber’ *Guardian* <http://www.guardian.co.uk/society/2009/feb/11/sir-george-godber-obituary> accessed 17.5.2013

²⁸⁷ Geoffrey Rivett, *National Health Service History*, <http://nhshistory.net/cv/godber.html> accessed 21.2.2012

both, external triggers of concern to the government may have been important. Warren's achievements were in line with war-time bed priorities and the plans for the welfare state. For Arie, in the aftermath of the Ely Hospital and *Sans Everything* inquiries, the DHSS might have been more open to ways of de-institutionalising mentally ill older people. Revived interest at the DHSS was suggested by the circulation of *Psycho-Geriatric Assessment Units* in March 1970,²⁸⁸ before the DHSS would have been able to respond to Arie's presentation to the Keppel Club which took place on Friday 20th March.²⁸⁹ This interest was likely to have contributed to Arie forging direct links within the DHSS. Personality factors and Godber's direct encouragement probably also facilitated the links, which allowed joint government-clinician collaboration, instead of the previous situation of the DHSS making psychogeriatric service policy decisions without guidance from specialists in the field.

Doctors, nurses and social workers in the development of psychogeriatrics

Arguably, government policy-makers should have ensured adequate services for older people in the light of evidence of increasing numbers and needs and demonstrated benefits of active interventions. However, they could more easily ignore the issue from a distance, especially given the range of concerns they faced, compared to socially-conscious health care professionals who witnessed the less than ideal care of older people and the difficulties they experienced.

Many factors contributed to the doctors' leadership in the psychogeriatric context. The medical profession was securely established in society and was male dominated. Established professional status perhaps enabled doctors to look outwards creatively rather than at their own organisation, despite having to deal with new NHS management structures imposed upon them.²⁹⁰ Senior doctors who undertook NHS management roles usually continued to have face-

²⁸⁸ DHSS, *Psycho-Geriatric Assessment Units*; Clerk of the Executive Council, covering letter, March 1970, ECN778 (KFL, DHSS circulars)

²⁸⁹ Arie, e-mail, 23.1.2012

²⁹⁰ MoH, *First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals* (Cogwheel Report) (London: HMSO, 1967)

to-face clinical responsibility for patient care, unlike nurses and social workers who would move away from front line work when promoted. Thus doctors could be enthusiastic about their patients as individuals, thoroughly understand their needs, and propose and organise local schemes to improve services. Their professional training aimed to equip them to undertake research, evaluate innovations and write up their findings for publication.

In the 1960s, doctors probably had more autonomy than the other professions to step outside conventional clinical specialty boundaries or make changes to their own careers and services, although within hospitals such moves would have to be sanctioned by the medical committee. Psychiatrists wanting to adopt service development roles could become medical superintendents (e.g. Macmillan) or work jointly with them (e.g. Whitehead with Barton). Some doctors took on new roles for defined experimental periods (e.g. Robinson, Fish and Williamson). Others retained a role within an established branch of the profession while testing their hypotheses outside it, such as Pitt and Arie continuing to work with younger people as a fall back position in case their career move to psychogeriatrics proved unsustainable.²⁹¹

In the context of multi-disciplinary treatment and care, the lack of involvement of other staff in initiating developments is noticeable, especially nurses and social workers during the 1960s. The following section aims explore the reasons for this.

Nursing: research, training and leadership

Although nurses were crucial to psychiatric and geriatric work, leading their own experimental or research approach to practice was almost non-existent. Nurse Doreen Norton²⁹² was unusual in that regard; she pioneered nursing research and investigated geriatric care in the 1960s.²⁹³ Journals such as the *Nursing Mirror* and *Nursing Standard* contained little nurse led research; most

²⁹¹ Pitt, interview by author, 2004; Arie (BLSA)

²⁹² Norton (BLSA)

²⁹³ Doreen Norton, Rhoda McLaren, AN Exton-Smith, *An Investigation of Geriatric Nursing Problems in Hospital* (London: NCCOP, 1962)

research and clinical articles were written by doctors for nurses.²⁹⁴ The same was apparent for textbooks of geriatric²⁹⁵ and psychiatric nursing.²⁹⁶ An exception was *Psychiatric Nursing* by Annie Altschul.²⁹⁷ Professor Altschul was a prolific writer who encouraged an enquiring approach to nursing. She was critical of nurse training, including its lack of encouragement of research. She commented that most nurses had not heard of nursing research in the 1950s, and not until the 1970s were nursing research units established.²⁹⁸

Innovation and service evaluation was not helped by the senior nursing management structure proposed by the Salmon Report in 1966.²⁹⁹ In particular, nurses with the greatest clinical experience did not retain caseloads if they moved into organisational roles.³⁰⁰ Removing experienced leaders from clinical work, combined with lack of research training, was unlikely to encourage or enable those in face-to-face contact with patients to facilitate change or pioneer and evaluate new clinical methods.

Social work: research, training and professional practice

Social work for older people spanned two professional groups, psychiatric social workers (PSWs) and almoners (medical social workers). Mentally ill older people were neither wholly the responsibility of PSWs nor of almoners, risking their needs being overlooked. There was little social work input into general practice where it might have been useful in view of the complex needs

²⁹⁴ e.g. C Beresford, 'Senile dementia' *Nursing Times*, 6.7.1962, 861-864; Richard Neville, 'Psychogeriatric day hospitals' *Nursing Mirror*, 11.8.1967, ix-x

²⁹⁵ e.g. Thomas Rudd, *The Nursing of the Elderly Sick: a practical handbook of geriatric nursing* (London: Faber and Faber, 1964)

²⁹⁶ e.g. Brian Ackner (ed.) *Handbook for Psychiatric Nurses* (London: Baillière Tindall and Cox, 1964)

²⁹⁷ Annie Altschul, *Psychiatric Nursing* (London: Baillière Tindall & Cassell, 1968); Barker, 'Annie Altschul'

²⁹⁸ Annie Altschul, 'The development of research in nursing' (c.1982) 1, 11 (RCNA, C305/1/2)

²⁹⁹ MoH and SHHD, *Report of the Committee on Senior Nursing Staff Structure* (Salmon Report) (London: HMSO, 1966)

³⁰⁰ 'Evidence of the Royal College of Psychiatrists to the Royal Commission on the National Health Service' (Draft) (c.1976) 2 (PJ)

of some older people living at home.³⁰¹ Training to work with older mentally ill people was largely ‘on-the-job’ in the few psychiatric hospitals with multi-disciplinary old age mental health teams.

The Mackintosh Report in 1951 outlined the roles of PSWs: taking patients’ social histories, ‘preventive and aftercare’ work, and liaising with families to prepare for discharge.³⁰² Two-thirds of qualified PSWs in the 1950s worked in child and adolescent services.³⁰³ The *British Journal of Psychiatric Social Work* reflected this in its content, to the exclusion of adult psychiatric patients of all ages. Despite earlier evidence from social workers that discharge was possible for older people,³⁰⁴ PSWs were unlikely to work with them. With PSWs’ remit for adults significantly concerned with ‘aftercare’, given expectations that younger rather than older people were more likely to be discharged, younger people were the main focus of their work.

Almoners, as an employed professional group rather than as skilled voluntary workers, were a relatively new resource.³⁰⁵ In the 1960s they endeavoured to establish their profession, rather than campaign for specific patient groups.³⁰⁶ There was some formal education about psychogeriatrics for almoners, such as a course taught by Felix Post and his social work colleague Catherine Colwell.³⁰⁷ A National Group of Geriatric Almoners with an educational focus was active in the 1960s.³⁰⁸

³⁰¹ Joan Collins, *Social Casework in a General Medical Practice* (London: Pitman Medical, 1965) 58

³⁰² MoH, *Report of the Committee on Social Workers in the Mental Health Services* Cmd 8260 (Mackintosh Report) (London: HMSO, 1951) 15

³⁰³ Margaret Ashdown, S Clement Brown, *Social Service and Mental Health: an essay on psychiatric social workers* (London: Routledge and Kegan Paul, 1953) 252-253

³⁰⁴ Lewis and Goldschmidt, ‘Social causes’

³⁰⁵ Phyllis Wilmott, ‘1895-1945: the first 50 years’ 1-11. In: Joan Baraclough, Grace Dedman, Hazel Osborn, Phyllis Wilmott, *100 years of Health Related Social Work: 1895-1995* (Birmingham: BASW, 1996) 1

³⁰⁶ Grace Dedman, ‘1946-1973: reconstruction and integration: social work in the National Health Service’ 21-47 In: Baraclough *et al.* *100 years*

³⁰⁷ Anon. ‘Prospectus, Department of Extra-Mural Studies, University of London’ *Almoner* (1961) 14: 288

³⁰⁸ National Group of Geriatric Almoners, *Almoner* e.g. (1962) 14: 529; (1962) 15: 188; (1963) 16: 48

Occasionally an article appeared in *The Almoner* about the needs of older people,³⁰⁹ but generally social work research and reports overlooked older mentally ill people,³¹⁰ even if inclusion was implied in the generic term 'adult'.³¹¹ A social work text book by E Matilda Goldberg occasionally gave case studies about older people.³¹² The only presentation on mental disorders in old age at a 'Mental Health and Social Work' conference in England in 1961 was from Israel. Erna Simson reported on the successful discharge of older patients resident in long-stay wards for up to 25 years, including some survivors of Nazi persecution. Simson reflected on the scepticism of her Israeli colleagues on the chances of success³¹³ much as achievements with older people in the UK surprised British practitioners. Her optimism was relevant to psychogeriatric social work in England, but whether it had any direct influence is unknown.

Changes in social work management structures proposed by the Seebohm Report in 1968 prioritised younger people.³¹⁴ The report originated from concerns about children's and probation services³¹⁵ and recommended reorganisation of social work into family orientated local area teams. This reduced the provision of specialist psychiatric and medical social workers and did not fit with the needs of older people. By moving from specialist to generic social work, Seebohm went against the direction taken by health care

³⁰⁹ Butrym, 'Discussion on casework'

³¹⁰ Association of Psychiatric Social Workers, *Relationship in Casework* (London: APSW, c.1963)

³¹¹ Elizabeth Irvine (ed.) *Mental Health and Social Work : report of a residential seminar held at Uplands, Four Ashes, High Wycombe, Bucks., England, in September 1961* (London: Association of Social Workers, 1963); Anthony Rees 'Problems of old age' 95-112. In: *The Social Workers: an introductory survey of social work today* (London: BBC, 1965)

³¹² E Matilda Goldberg, *Welfare in the Community* (London: National Council of Social Service, 1966) 28-29

³¹³ Erna Simson, 'The mentally disturbed aged' 13-17. In: *Mental Health and Social Work* ed. Irvine

³¹⁴ Committee on Local Authority and Allied Personal Social Services (Seebohm Report) Cmd. 3703 (London: HMSO, 1968)

³¹⁵ Rodney Lowe, *The Welfare State in Britain since 1945* (Houndmills: Macmillan Press, 1999) 268

professions.³¹⁶ Recalling the age prioritisation in the Beveridge report,³¹⁷ older and younger people competing for the same finite pot of resources had not produced equitable services, and it was doubtful whether the new social services structure would improve that. Geriatrician John Agate asked whether ‘older people under the care of the social services department [will] get a sufficient share of the resources in face of a demand to relieve the distress of children’.³¹⁸

In the 1960s, most social workers, like nurses, received little or no research skills training³¹⁹ and were rarely involved in old age research or in initiating psychogeriatric service developments. Social work philosophy incorporated a non-judgemental approach, or impartiality, to individual casework.³²⁰ Some social workers thought this might have prevented social workers from taking active roles in determining policy even when they saw ‘serious deficiencies in the social services’.³²¹ PSWs were said to influence policy, but this did not appear to extend to psychogeriatric services.³²² As with nursing, the post-Seebohm hierarchical work structure removed senior staff from direct care, which, when combined with a non-judgemental approach and lack of research training was unlikely help social workers to question, change and evaluate service provision.

Conclusions

Public disquiet and government discomfort about deficits in long-stay care raised by the *Sans Everything* and Ely Hospital scandals probably influenced DHSS action. The DHSS established the HAS and responded constructively to

³¹⁶ Len Ratoff, ‘Seebohm and the mental health services: reflections from general practice’ *SWT*, 2.11.1972, 3: 15: 3-6

³¹⁷ Beveridge, *Social Insurance*, 92

³¹⁸ John Agate, ‘Hospitals and community care’ 30-39. In: John Agate, Michael Meacher, *The Care of the Old* (London: Fabian Society, 1969) 39

³¹⁹ Noel Timms, *Psychiatric Social Work in Great Britain 1939-1962* (London: Routledge and Kegan Paul, 1964) 41

³²⁰ Butrym, ‘Discussion on casework’ 325

³²¹ Barbara Wright, ‘Society and the individual’ *Almoner* (1963) 16: 18

³²² Timms, *Psychiatric Social Work*, 11, 218-230

Arie's timely revelations on treating and discharging psychogeriatric in-patients and providing community services.

Clinical, epidemiological and scientific research improved understanding of older people's mental illnesses and needs, and demonstrated the effectiveness of interventions. However, there were still no official guidelines or mandatory directives for providing services. For older mentally ill people, except in a very few places, attitudes and services hardly shifted. The *Hospital Plan*, in the light of more liberal and community focussed mental health legislation, could have enabled real change for older people, but many continued to be admitted to psychiatric hospitals, probably clinically unnecessarily, but with little available alternative. The theme and risks of misplacement hovered, but the transition from psychiatric hospital to DGH was slow.

The Conservative government until 1964 and the Labour government until the end of the decade failed to put recommendations into practice, similar to their inactivity in previous, more austere years. Implementation was haphazard rather than incremental. A *laissez-faire* outlook predominated and there was a sense of stagnation. Lack of action, despite increasing evidence of what could be achieved, raises questions about barriers to implementation such as negative attitudes of public and professionals toward older people.

Chapter 4

Framing the context of psychogeriatric service development in the 1970s and 1980s

This is a very fine country to be acutely ill or injured in, but take my advice and do not be old or frail or mentally ill here – at least not for a few years.

Sir Keith Joseph, Secretary of State for Social Services, 1970-74¹

Introduction

Through the 1970s and 1980s, clinical knowledge about psychogeriatrics increased and more people from various disciplines and organisations entered the field. In the early 1970s, the emerging specialty underwent a transition from psychiatrists creating services in relative isolation to a national scheme led by inspired individuals. There was more debate, discussion and expression of opinion. A comprehensive historical investigation of the specialty therefore becomes more complex. A ‘jigsaw’ model, as used in the earlier chapters, aiming to create a comprehensive picture by combing a diversity of material in a shorter time frame, risks becoming confusing. With psychogeriatric aims, objectives and leadership generally consistent over the two decades, this period is therefore analysed in four thematic ‘time-line’ chapters dealing with: social attitudes to older people and health care in their political and economic contexts; developing services; partners, participants, opponents and admirers; achieving official recognition.

A report by WHO, *Psychogeriatrics*, in 1972, emphasised the need for widespread and adequate services based on the ‘epidemiology, origin, prevention, development and treatment’ of psychiatric disorders in old age.² It also expressed disappointment at the generally inadequate implementation of their 1959 recommendations.³ WHO described community care for older people as a ‘stirring slogan’, more rhetoric than a ‘realistic alternative’ to

¹ Anon. “‘Hospital Slums’ - Sir Keith” *Daily Telegraph*, 30.6.1973, 1

² WHO, *Psychogeriatrics*, 11

³ WHO, *Problems of Aging*

institutional care.⁴ International neglect of older people's mental health did not justify the situation in England. England risked lagging behind even its immediate neighbours. The devolved government health departments in Scotland⁵ and Northern Ireland⁶ issued plans for psychogeriatric services in 1970. The Northern Ireland plan asserted that insufficient resources contributed to undermining doctors' enthusiasm for working with older mentally ill people, a remark which was likely to have resonance elsewhere.⁷

This chapter introduces new terminology related to psychogeriatrics which came into use during the 1970s and 1980s, then considers social attitudes and health care in their political and economic contexts. These overlapped and tempered the development of health and welfare services, including psychogeriatrics.

Terminology

The new psychogeriatricians treated combinations of organic and functional psychiatric disorders, which interacted with physical illness and social difficulties, and were frequently associated with behavioural disturbances – 'the real "nitty gritty" of Psychogeriatrics'.⁸ However, rather like 'community care', the term 'psychogeriatrics' lacked a clear origin and definition. It could be unhelpful, and sometimes controversial. In the early 1970s, when the specialty was small, and in many places did not exist, it was hardly surprising that there were diverse perspectives on its meaning. White commented that 'Part of the problem of the acquired respectability of the term is that people are beginning to believe that it really has a meaning'.⁹ Isaacs in 1974 commented: 'Psychogeriatrics is understood in different ways by different people and

⁴ WHO, *Psychogeriatrics*, 10

⁵ SHHD, Scottish Health Services Council, *Services for the Elderly with Mental Disorder* (Millar Report) (Edinburgh: HMSO, 1970)

⁶ MoH and Social Services, *Geriatric and Psychiatric Services for the Elderly* (Belfast: HMSO, 1970)

⁷ *Ibid.* 2

⁸ Group for the Psychiatry of Old Age (GPOA), minutes, 10.10.1973, 2.b.iii. (RCPsychA)

⁹ DMD (Michael) White, 'Psychogeriatrics - what next?' *Lancet* (1972) ii: 223-224 223

should no longer be used'.¹⁰ A committee of inquiry into the deaths of elderly patients transferred between hospitals in Lancashire in 1973/4 also voiced discomfort: 'psycho-geriatric', they said, was used pejoratively in health services to denote 'unwanted' confused older people.¹¹ The DHSS tried 'to discourage its use',¹² although precisely how was unclear. Others queried its concepts and roles. One group of geriatricians and psychiatrists concluded that general psychiatrists had sufficient expertise to treat patients of all ages so a separate specialty of psychogeriatrics was unnecessary;¹³ many psychiatrists might have had relevant skills, but there is little evidence that they had the desire. At a meeting organised in 1972 by the King's Fund (an independent research and policy charity aiming to improve the health system in England) an anonymous participant labelled psychogeriatrics 'largely a social problem'.¹⁴ Social factors were undoubtedly important in managing all psychiatric disorders and influencing the likelihood of institutionalisation, but defining psychogeriatrics as a 'social problem' contradicted available biological evidence and implied that there was little or no need for, or likely benefit from, psychiatric involvement. The variety of views indicated future challenges for the psychogeriatricians.

For involved clinicians, the self designated label of 'psychogeriatrician'¹⁵ or 'old age psychiatrist' implied a proud dedication to the field. Other labels for psychiatrists working with older people were ambiguous. For example, 'psychiatrist with a special interest' in old age could mean the same as psychogeriatrician or old age psychiatrist, or could imply one appointed to such a role, often secondary to their main work with younger people and with little enthusiasm to work with older people. The term 'psychiatrist with special

¹⁰ Bernard Isaacs to Pitt, letter, 11.12.1974 (PJ)

¹¹ North Western Regional Health Authority (RHA), 'On the transfer of patients from Fairfield Hospital to Rossendale Hospital' (1975) 14 (TA)

¹² DHSS, 'Departmental response to Committee's recommendations' (Hospital Inquiry) (c.1975) General recommendations, b. (TA)

¹³ J Andrews *et al*, 'Planning of psychogeriatric care: report of a joint working party of geriatric physicians and psychiatrists' *Gerontologia Clinica* (1972) 14: 100-109 101

¹⁴ King's Fund Centre, 'Care for the Elderly Mind' 23 (KFL, Class number QBFA)

¹⁵ John Wattis, Libby Wattis, Tom Arie, 'Psychogeriatrics: a national survey of a new branch of psychiatry' *BMJ* (1981) i: 1529-1533 1530

responsibility’¹⁶ for older people implied a service development role. All the terms were used by health authorities appointing consultant psychiatrists to work with older people, suggesting various degrees of understanding and expectations of the specialist nature of the work and the resources required to support it.

Other ambiguous terms widely used in the 1970s may be encountered in primary sources but can otherwise be avoided. The term E(S)MI, initially designated ‘elderly (severely) mentally infirm’ and later ‘elderly (severely) mentally ill’, had a range of connotations of infirmity or illness. Another ambiguity arose from the introduction in 1957 of the concept of the ‘norm’. It was used, for example, for provision of beds. It was an arbitrarily set administrative tool, above which provision could be reduced and below which it needed improvement, but it was neither a maximum nor minimum, and certainly not an optimum.¹⁷ Psychogeriatricians found the term useful for negotiations with authorities when their local provision was ‘below the government norms’.¹⁸

Definitions had benefits and risks which were apparent when psychogeriatricians were arguing their cause. Clear definitions could enable good communication, provide a shared understanding for negotiations and a sense of direction, important for generating policies and facilitating implementation. Vague or tight definitions could create boundaries of exclusion and disputes over clinical and social care responsibilities.¹⁹ Disputes were particularly marked when resources were restricted or unequal, circumstances which could inhibit sharing and encourage territorial demarcation of care boundaries, risking undermining patient care.²⁰ Some tight

¹⁶ DHSS, *Services for Mental Illness Related to Old Age* HM (72)71 (London: HMSO, 1972) 6

¹⁷ Paul Bridgen, Jane Lewis, *Elderly People and the Boundary between Health and Social Care 1946-1991: whose responsibility?* (London: Nuffield Trust, 1999); David Jolley, Tom Arie, ‘Psychiatric service for the elderly: how many beds?’ *BJPsych* (1976) 129: 418-423 421

¹⁸ Arie, e-mail, 12.5.2012

¹⁹ NHS, *Annual Report of the Hospital Advisory Service to the Secretary of State for Social Services and Secretary of State for Wales for the year 1974* (London: HMSO, 1974) 30

²⁰ White, ‘What next?’ 223

definitions implemented by the small number of psychogeriatricians who offered specialist services might have helped them deal with the fear, common to those setting up new services, of being impossibly swamped.²¹

Social values: ageism and interest

The values of society require exploration since they can influence public bodies, and therefore the provision of health and social services.²²

Discrimination towards people previously perceived as unequal, such as women, disabled people, homosexuals and ethnic minorities showed some diminution associated with new legislation in the 1960s, but a change of attitude was less evident towards older people, gypsies and some religious groups.²³ Overt ageism was uncommon, but covert ageism detected in governmental and medical sources might influence priorities and practices. For example, negative generalisations about older people's capacities for activity and independence were represented in an official population graph in 1981 (Fig 13). Some truth was expressed in the images, but they did not represent the extent of variation in social activity and wellbeing, including excellent health, within each age group. Psychogeriatricians encouraged age appropriate services for those who required them, but that was not the same as the tendency by government departments or people in everyday discourse to label everyone above a certain age as requiring similar assistance, which reinforced unhelpful ageist stereotypes.²⁴

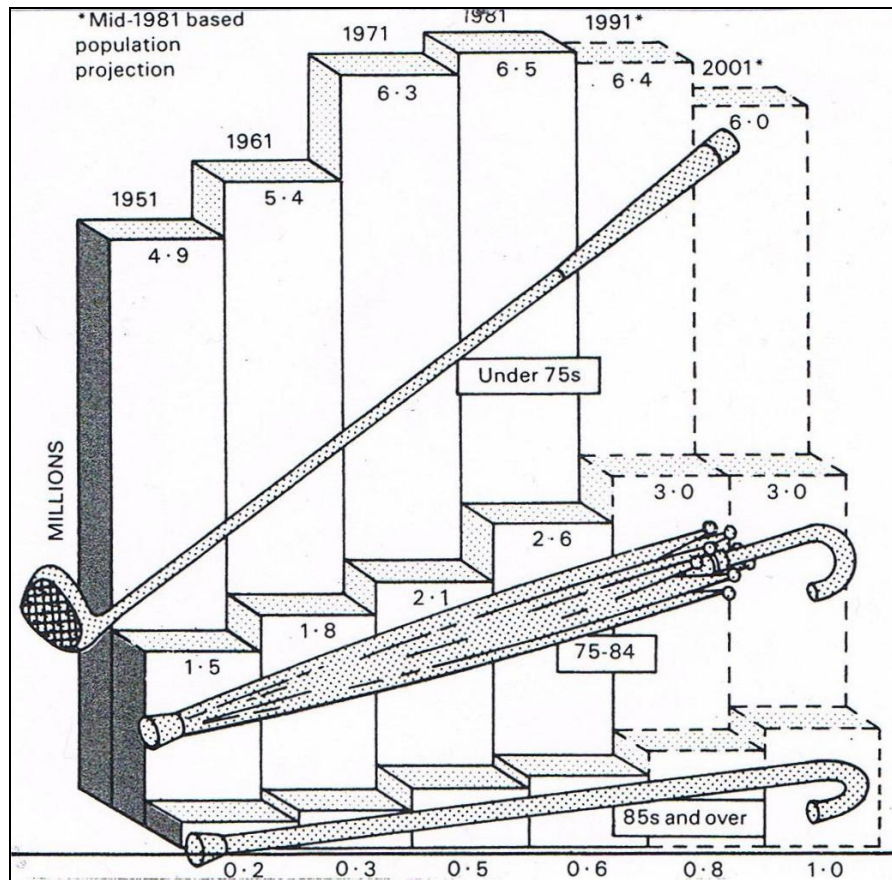
²¹ Pitt, interview by author (2006); BMA, *When You are Old*, 13

²² *Report of the Royal Commission on the National Health Service* (Merrison Report) Cmnd. 7615 (London: HMSO, 1979), 356

²³ Julia Neuberger, 'Foreword' ix-xi. In: *Unequal Britain* ed. Thane

²⁴ Office of Population Census and Surveys, *Census Guide 1: Britain's elderly population 1981 Census* (London: HMSO, 1984)

Fig 13. 'Numbers of the elderly by broad age groups', Great Britain, 1951-2001



Source: OPCS, Britain's Elderly Population, 1 (Copyright permission: OGL)

Penguin Books, popular publications for an educated lay audience, published several books on old age at this time. In 1970, Whitehead's *In the Service of Old Age* described the achievements at Severalls.²⁵ Penguin commissioned it in the aftermath of the high profile care scandals.²⁶ The book aimed 'to inform public opinion of what can be done and to stimulate self scrutiny by authorities who should be doing more'.²⁷ Despite the intentions and the enlightened view of Penguin, only 1000 copies sold each year and in 1973 the remaining 4,752 copies were pulped.²⁸ Ivor Felstein's *Later Life*, a solution-focussed book about geriatric medicine which closely paralleled Whitehead's book also had

²⁵ Pages 182-185

²⁶ Catherine Storr to Whitehead, letter, 27.11.1967 (Penguin Books Archive)

²⁷ Russell Barton, 'Foreword' 9-10. In: Whitehead, *Service of Old Age*, 9

²⁸ Hannah Lowery, archivist, e-mail concerning letter, 26.2.1973; Julia Vellacott to Peter Wright, letter, 10.6.1975 (Penguin Books Archive)

only one edition.²⁹ This contrasted with *The Psychology of Human Ageing*³⁰ by Dennis Bromley, a more comforting text, mainly about ‘normal’ ageing. It was revised once and reprinted seven times.³¹ It hardly touched on the uncomfortable areas of chronic illness, disability, dependency and death, the scandals or the challenges of improving services. Many people, it seemed, did not want to know about those aspects of getting older which were uncomfortable reading, psychologically and politically. Whitehead’s and Felstein’s messages of humane clinical practice and inspired solutions did not capture public interest, contrasting with the attention paid to the *Sans Everything* and Ely Hospital scandals.

Ageism within psychiatric hospital services appeared in the generally constructive plan for old age services in Northern Ireland in 1970. It is unlikely that England differed dramatically. The Northern Ireland plan commented that older people might only be admitted to psychiatric hospitals in emergencies, in contrast with a more proactive service for younger people. It also stated that older people ‘often have to go through the general admission unit, to the distress of younger patients and the detriment of the service’.³² It did not mention that older people might be distressed by disturbed younger patients. It blamed ‘an increasing proportion of the population ... surviving into advanced old age and putting an increasingly severe strain’ upon health and community services,³³ appearing to forget that the NHS was meant to be universal.

Geriatrician Colin Currie illustrated ageist attitudes among clinicians:

Would we dare translate our less amiable generalisations about elderly patients, our more exasperated reactions to them, directly into terms of colour? (‘Don’t you find it depressing working with black patients all the time?’ ‘Twelve new admissions last night and only three of them white.’

²⁹ Ivor Felstein, *Later Life: geriatrics today and tomorrow* (Harmondsworth: Penguin Books, 1969)

³⁰ Dennis Bromley, *The Psychology of Human Ageing* (Harmondsworth: Penguin Books, 1967 and 1974)

³¹ *Ibid.* (1974) Front matter

³² MoH and Social Services, *Geriatric and Psychiatric Services*, 4

³³ *Ibid.* 1

‘How can I be expected to run a teaching medical ward with all these beds blocked by, ahem, ethnic minorities?’) ... Perhaps some doctors are ageist, some of the time at least.³⁴

Attitudes to illness and disability in old age did not generally improve during the 1980s, at least not sufficiently to influence service provision widely. A joint geriatric, psychiatric and nursing report in 1987 noted that ‘the low worth of old people and their therapeutic potential still persist despite the dramatic evidence to the contrary’.³⁵ Terminology used by staff indicated their unhelpful views. A manual for training staff working with confused older people commented that terms such as ‘dement’, ‘babies’, and ‘semis’ (probably meaning ‘not all there’ or semi-human) were commonly used.³⁶ Isaacs expressed his discomfort with the widely and imprecisely used phrase ‘the elderly’ which implied a depersonalised homogeneity rather than individuals and diversity.³⁷ Concerning hospitals, professor of psychogeriatrics, Elaine Murphy commented in 1986 that derogatory labelling of chronically ill older patients as ‘social problems’, ‘contributes to therapeutic despondency in the ward team ... elderly people do not deserve to be bracketed with soccer hooligans’.³⁸ For mental illness, stigma and fears over and above those for physical illness probably deepened negativity. It is likely that underlying attitudes contributed to hurdles for clinicians trying to create, improve and provide psychogeriatric services.

Health care: modernising psychiatry

The Royal College of Psychiatrists

An important organisational change in 1971 was the establishment of the RCPsych, which developed from the RMPA. The RCPsych came to have a major influence on psychiatric practice in the UK. Medical Royal Colleges, regulated by law, are responsible for ensuring high standards of clinical work

³⁴ Colin Currie, ‘Doctors and ageism’ *BMJ* (1987) 295: 1586

³⁵ BGS/RCPsych/RCN, *Improving Care of Elderly People in Hospital* (London: RCN, 1987) 5

³⁶ Joan Rush, Tom McAusland, *A Guide to Training Resources for Staff Working with “Confused” Elderly People* (London: Kings Fund Centre, 1982) 4

³⁷ Isaacs, ‘Let’s abolish “the elderly”’

³⁸ Elaine Murphy, ‘Hazards for elderly people admitted for respite and social care’ *BMJ* (1986) 292: 481-482 482

and establishing accredited training schemes and professional examinations. Standards of psychiatric practice were ‘abysmally low’, according to the RCPsych in 1974.³⁹

Alongside general psychiatry, four RMPA specialist committees automatically became ‘Sections’ of the new RCPsych: forensic psychiatry, psychotherapy, mental subnormality and child psychiatry. When new clinical interests appeared, such as in old age, the College approved special interest ‘Groups’, smaller and of lower hierarchical status than Sections. The ‘Group for the Psychiatry of Old Age’ (GPOA) began in 1973,⁴⁰ becoming a Section (SPOA) in 1978. In the light of creative psychogeriatric services being developed, it is surprising that the RCPsych did not rapidly encourage the specialty in order to improve standards. However, old age was only one of their concerns.

Changing psychiatric services

During the 1970s mental health services for people of all ages were changing in Britain and other western countries. Psychiatric hospitals often had architectural features considered un-therapeutic: Nightingale wards, no lifts, unwieldy confusing corridors, un-homely environments and toilet facilities at a distance from the patients’ beds. These discouraged independence, particularly for mentally and physically frail people. Influenced by social, ideological and economic considerations, custodial psychiatric hospitals were closing, giving way to community services with psychiatric departments incorporated into general hospitals.⁴¹

Community care remained a loosely defined concept,⁴² and some, such as social rights journalist Paul Harrison, questioned whether it really existed.⁴³ Some vehemently opposed psychiatric hospital closure as much as others

³⁹ Manpower Committee, ‘Memorandum on psychiatric manpower as it affects the psychiatric services: to be presented to the Central Manpower Committee’ (1974) MSC6/74, 1 (RCPsychA)

⁴⁰ GPOA, minutes, 9.2.1973, 2 (RCPsychA)

⁴¹ MoH, *Hospital Plan*, 6

⁴² Welshman, ‘Rhetoric and reality’ 205-207

⁴³ Paul Harrison, ‘The careless community’ *New Society*, 28.6.1973, 743-745

welcomed it. For example, social worker Diane Tucker⁴⁴ commented in the *Lancet*:

the community has no structure within which to contain the destructiveness of people who have no control over their infantile aggressiveness ... we must keep the socially disruptive mentally sick people in the mental hospitals where they belong.⁴⁵

Tucker may have been broadly correct about deficits in community care structure. Some older people could undoubtedly be very disruptive, but ‘destructiveness’ is rare in any mental disorder; her comments might have applied to a very small minority of patients, but were not generalisable. To assume that containment was needed and nothing could be done to ameliorate difficult behaviours was a disparaging view of modern psychiatric and psychological interventions. Although powerful statements of opposition indicated limited understanding, they risked preventing closures and suggested that former psychiatric in-patients might be unwelcome in the community.

Improving mental health services would require across-the-board changes in the community and in hospitals, better training for staff, and, some envisaged, increased public expenditure.⁴⁶ The White Paper *Hospital Services for the Mentally Ill* in 1971⁴⁷ set ‘admirable goals’, but MIND criticised it as ‘dangerously superficial’ because it failed to indicate how the goals would be achieved.⁴⁸

⁴⁴ Diana Tucker, ‘Depression on holiday’ *BMJ* (1976) ii: 1074

⁴⁵ Diana Tucker, ‘Number of mental health beds’ *Lancet* (1972) ii: 971

⁴⁶ J Bradley, ‘Hospital Services for the Mentally Ill’ *BMJ* (1971) iv: 811

⁴⁷ DHSS, *Hospital Services for the Mentally Ill* HM (71)97 (London: HMSO, 1971)

⁴⁸ Bradley, ‘Hospital Services’

Health care: high-tech *versus* psycho-social interventions

Rapidly advancing technology had the potential to help people in all age groups. The first human heart transplant took place in 1967. Coronary artery bypass grafts, more sophisticated surgery, computerised axial tomography (X-ray CAT scans) and renal dialysis, were becoming commonplace.

Benefits of new interventions for acute physical disorders were at times dramatic. They were easier to measure and quantify than the changes observed in chronic illness management. The widely used measure of clinical improvement, the 'QALY' (quality adjusted life year), introduced in 1972, had little relevance to treatment for chronic or degenerative disorders.⁴⁹ For example, behavioural improvements in people with dementia could profoundly impact on the patient and the carer, but would not register on the QALY scale.

Hip replacements were developed with older people in mind.⁵⁰ This procedure, in line with the acute hospital ethos of rapid treatment and discharge, was hugely beneficial to many older people. However, a report to the Cabinet in 1977 did not mention humane reasons for doing hip replacements, but suggested that the government might have encouraged the procedure because it could envisage financial advantages:

£1 million spent on total hip replacement for the elderly would preserve mobility and reduce the need for long term care, perhaps generating an annual return of £0.6 million for an average five years in terms of [health and social services] expenditure.⁵¹

While interest in highly technical clinical work was increasing, work with mainly older people with chronic and degenerative disorders was devalued.⁵² If there was inadequate provision for acute illness, due to threatened closures of

⁴⁹ Rosser RM, Watts VC, 'The measurement of hospital output' *International Journal of Epidemiology* (1972) 1: 361-368

⁵⁰ John Charnley, 'Arthroplasty of the hip' *Lancet* (1961) i: 1129-1136

⁵¹ Report by the Public Expenditure Survey Committee: part 2: Detailed Analysis of Programmes and Supplementary Analyses. Cabinet papers, 4.7.1977, 111 (TNA, CAB 129/197/3) 111

⁵² Tony Smith, 'Who should be looking after grandpa?' *Times*, 21.2.1978, 18

accident and emergency departments, public outcry was likely,⁵³ but there was little evidence of protest, and rarely any public comment, if mental illness, especially in old age, was overlooked.⁵⁴

One medical specialty which contrasted with psychogeriatrics was cardiology, providing often dramatic, high-tech acute life saving interventions, frequently for younger people. Compared with editorials about psychogeriatrics, those in the *British Heart Journal* in the 1980s were largely self congratulatory and expressed no concern about obtaining resources. Not only was resourcing different, but physicians in prestigious acute specialties who might be regarded as spokesmen for hospital consultants generally, did not appear to understand the nature of psychogeriatrics. For example, a letter in the *BMJ* from cardiologist Thomas Pickering (working in the USA at the time) commented that psychogeriatricians did not need specialist training as nothing could be done for their patients except 'general supportive care'.⁵⁵ It sparked at least 14 letters opposing him, a large number by *BMJ* standards, mainly from geriatricians and psychogeriatricians.⁵⁶ Opinions rather than evidence cited by influential medical personnel might contribute to diverting resources away from psychogeriatric services.

Another illustration of prioritisation, this time concerning medical research, was the rapid introduction of new high-tech anti-retroviral medication for the Human Immunodeficiency Virus and Autoimmune Deficiency Syndrome (AIDS). AIDS, an acute fatal illness, was identified clinically in the 1980s. It was converted by new and costly medication, provided by the NHS, to a chronic, manageable disorder in the 1990s. Initially, mainly younger men

⁵³ Diana Geddes, 'Clash over closure plans for hospital' *Times*, 1.10.1976, 3; Penny Symon, 'Hospitals forced to turn away ambulance patients' *Times*, 28.7.1978, 4

⁵⁴ Jack Ashley, 'National Health Service' HC Deb 6.11.1981 *Hansard* Vol. 12 cc220-81 <http://hansard.millbanksystems.com/commons/1981/nov/06/national-health-service> accessed 4.6.2013

⁵⁵ Thomas Pickering, 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 377, 791

⁵⁶ 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: individual letters: Brice Pitt, DMD White, Colin Godber, Brian Livesley, M Keith Thompson, Felix Post, G Winyard, Susan Chapman, 494-496; James Williamson, R Kennedy, Donald Melville, Klaus Bergmann, 671-672; Peter Sleight, 791; Christopher Turnbull, 992

benefited. Although treatment may have been easier to develop than for the dementias, the unanswerable question is whether expensive high-tech drugs would have been intensively researched and developed for an affected population who were mainly older and female, however obvious the need. This question is also suggested by evidence that older people were excluded from various types of medical research,⁵⁷ sometimes without reasons being given.⁵⁸ Excluding older people from drug trials was recognised as hazardous.⁵⁹ Drugs likely to be prescribed for them were mainly trialled on younger people who had different physiological characteristics and thus sensitivities to medication. An example within psychiatry was the antidepressant fluoxetine (Prozac), first marketed in 1986;⁶⁰ for older people, preliminary studies only began two years later,⁶¹ delaying establishing the benefits and risks of prescribing it for them.

The Medical Research Council (MRC), a major source of research funding, made constructive suggestions to encourage research into dementia.⁶² However, they appeared complicit in the lack of research: in 1986/7 they spent £591,000, 0.48% of their total budget, 'on research related to the elderly'. That compared unfavourably with the National Institute of Ageing in the USA which had a budget of over \$156 million in 1986.⁶³ In the view of psychogeriatrician Peter Jefferys: 'The MRC ... had one or two specialist units – but otherwise it was generally grudging'.⁶⁴ The MRC identified non-technical barriers to research, some of which resembled obstacles to clinical practice: low government priority; ongoing misconceptions of the relationship between ageing and dementia; patients in psychiatric hospitals remote from centres of research; and

⁵⁷ Michael Shepherd, 'Psychiatric research in perspective' *BMJ* (1981) 282: 961-963; MRC, *The Health of the UK's Elderly People* (London: MRC, 1994) 37-43

⁵⁸ David Goldberg, Peter Huxley, *Mental Illness in the Community: the pathway to psychiatric care* (London: Tavistock, 1980)

⁵⁹ Christopher Smith *et al.* 'Drug trials, the 'elderly' and the very aged' *Lancet* (1983) ii: 1139

⁶⁰ Shorter, *History of Psychiatry*, 419

⁶¹ C Brymer, C Winograd, 'Fluoxetine in elderly patients: is there cause for concern?' *Journal of the American Geriatrics Society* (1992) 40: 902-905 902

⁶² Medical Research Council (MRC), *Senile and Pre-senile Dementias: a report of the MRC subcommittee* (compiled by W Alwyn Lishman) (London: MRC, 1977) 21-22

⁶³ Tessa Richards, 'Research into aging: exploding myths' *BMJ* (1988) 296: 659

⁶⁴ Peter Jefferys, 'Witness' 42

the diversity of medical specialties involved including psychiatry, geriatrics or, generally for younger patients, neurology.⁶⁵

Undoubtedly, older people benefited from new high-tech clinical procedures, but were often excluded, e.g., from renal dialysis, on grounds of chronological age. Not until the 1990s was more attention paid to clinical factors which might indicate, more effectively than age, prognosis and response to treatment.⁶⁶

There were some restrictions of funding for high-tech medicine and surgery, but illnesses requiring a lower-tech approach were harder hit.⁶⁷ Although psychiatrists might require high-tech facilities of DGHs to diagnose mental illness, late twentieth century psychiatry was appropriately regarded as a generally low-tech specialty; medications and skilled, effective psycho-social interventions were the mainstay of treatment. Harvard professor of psychiatry, Leon Eisenberg, criticised the USA and UK governments for delays in incorporating psycho-social interventions into policy and practice:

When discoveries come in the form of more effective new drugs and procedures, they are readily introduced into practice. When they come in the form of remedies which counter deeply held beliefs, or are costly and manpower intensive, they compete in the political arena with other social values.⁶⁸

Valued high-tech interventions largely reinforce traditional illness roles of active-doctor and passive-patient. This contrasts with psycho-social interventions which require active involvement of patients and may challenge society's expectations. Psycho-social approaches struggled when competing for resources within the same finite funding pot. Arie commented in 1985 that rationing of care caused anguish for many practitioners and that

⁶⁵ MRC, *Senile and Pre-senile Dementias*, 9-10

⁶⁶ Shahid Chandna *et al.* 'Is there a rationale for rationing chronic dialysis? A hospital based cohort study of factors affecting survival and morbidity' *BMJ* (1999) 318: 217-223

⁶⁷ Anon. 'The truth about the NHS' *BMJ* (1986) 292: 1623-1624

⁶⁸ Leon Eisenberg, 'The relationship between psychiatric research and public policy' *BJPsych* (1988) 153: 21-29 28

psychogeriatrics ‘largely missed the boat of the prosperous ‘60s, and we have never known a time when resources were other than short’.⁶⁹

The first NHS reorganisation

In 1972, concerned about public expenditure, the Conservative government planned to ‘reorganise’ the NHS.⁷⁰ Retrenchment was an objective, as with the Guillebaud Report in 1956.⁷¹ Reorganisation would allegedly ‘unify’ and improve the NHS, and ‘deploy scarce resources’.⁷²

The oil crisis in 1973 and the stock market crash in 1973/4 were associated with financial difficulties internationally. In Britain, soaring inflation and agreements for a large loan (\$3.9 billion) from the International Monetary Fund required curbs on public sector expenditure.⁷³ Reorganisation apparently became unavoidable. The Labour government came into office in March 1974. Reorganisation was implemented a month later.

Reorganisation included constructive proposals for catchment area frameworks for planning, coordinating, integrating and improving preventive, community, domiciliary and chronic illness services. These proposals complemented improvements in hospital care which earlier had been given ‘legitimate priority’.⁷⁴ Organising health care in areas coterminous with local authority social services⁷⁵ was potentially beneficial for older people with complex needs. They might have benefited even more from a single authority providing services. This could have improved coordination and avoided disputes between

⁶⁹ Tom Arie, ‘Old age psychiatry over 15 years’ *SPOA Newsletter* (1985) 7: 2-5 3

⁷⁰ DHSS, *National Health Service Reorganisation (England)* Cmnd. 5055 (London: HMSO, 1972)

⁷¹ Webster, *Political History*, 32-33

⁷² Keith Joseph, ‘Foreword’ v-vii. In: DHSS, *National Health Service Reorganisation: England* Cmnd 5055 (London: HMSO, 1972) v-vi

⁷³ Chancellor of the Exchequer, ‘IMF Negotiations, memorandum’ 22.11.1976, 3 (TNA, CAB 129/193)

⁷⁴ Joseph, In: DHSS, *Reorganisation*, v

⁷⁵ DHSS, *Reorganisation*, 7

authorities about responsibilities, as a number of people, including Balniel, suggested:

Just as we were right to pull down the walls which surrounded the mental hospitals, it is essential that we pull down the walls which divide the hospital service from the local authority health and welfare services.⁷⁶

Reorganisation unified services in the sense of bringing local authority-led health services into the NHS, but it did not amalgamate health and personal social services, despite the DHSS recognising ‘very strong arguments’ for doing so.⁷⁷ No reasons were stated in the reorganisation White Paper. Stakeholders held different views on funding and the division of authorities’ responsibilities; the needs of older people were only part of the wider debate. Cabinet minutes recorded opposition from the medical profession to a fully unified service and it was ‘ruled out by considerations of financial accountability’ between the NHS and local authorities, although the exact meaning of this was unclear.⁷⁸ Others argued that personal social services should be aligned with housing and education.⁷⁹

For the NHS, the time and emotional energy spent on the process of reorganisation diverted the minds of some staff from the problem of inadequate services, due to the claim that it, rather than more resources, could improve the situation. Some doctors, as with earlier changes,⁸⁰ voiced concern that older people would not receive a fair share of health and social care resources.⁸¹ As Webster reflected, the changes did not achieve the desired objectives of improvement⁸² and ‘Gloomy voices declared that 1975 represented the death

⁷⁶ Balniel, ‘Mental Hospitals’ HC Deb 11.2.1970 *Hansard* Vol. 795 cc 1335-1396 1339 <http://hansard.millbanksystems.com/commons/1970/feb/11/mental-hospitals> accessed 26.1.2013

⁷⁷ DHSS, *Reorganisation*, 2

⁷⁸ ‘Cabinet Conclusion 5: reorganisation of the National Health Service’ 15.1.1970, 13 (TNA, CAB 128/45)

⁷⁹ Royal Institution of Chartered Surveyors, ‘Government proposals for reorganisation of local government in England’ 5.b. (TNA, MH 166/135)

⁸⁰ Agate, ‘Hospitals and community care’ 39

⁸¹ JA Muir Gray, ‘Geriatrics, politics and the BGS’ *Age Ageing* (1976) 5: 125-126 125

⁸² Webster, *Political History*, 110

knell of the welfare state'.⁸³ Clinicians in many medical disciplines viewed reorganisation sceptically.⁸⁴ The new, cumbersome management structure, including regional, area and district organisational tiers, largely removed doctors from decision making within hospital management. In 1977, an internal DHSS memorandum noted that clinicians 'made positive suggestions only to find their proposals lost in the administrative quagmire of the reorganised NHS'.⁸⁵ This was problematic; a centrally led NHS had the authority to make widespread improvements, but the inspiration and leadership for clinically effective old age services had consistently come from hospital consultants working directly with patients, rather from than the centre or any other source. In 1976, the RCPsych, which valued local creativity, suggested the 're-introduction of a body of educated people to whom one could turn at hospital level rather than the present situation of dealing with faceless voices'.⁸⁶

After reorganisation, it was hard to identify improvement in mental health services. In 1975, Barbara Castle, Labour Secretary of State for Social Services, commented that psychiatric services would continue to be based in psychiatric hospitals for some years, as little progress could be made until the economic situation improved.⁸⁷ Despite optimistic policies, financial constraints caused limitations, affecting many vulnerable people.⁸⁸

Inequalities and economics

It was well recognised that poverty was particularly prevalent among older women and all very old people and affected health in all age groups.⁸⁹

⁸³ *Ibid.* 74

⁸⁴ J Robson, S Iliffe, J LeFanu, 'Reorganisation of the NHS' *Lancet* (1972) ii: 648-649; David McKie, 'Those two reorganisations' *Lancet* (1973) ii: 1434

⁸⁵ DHSS internal memo, Dr J Charles-Jones to Mr Simon, 14.12.1977 (TNA, MH 154/1066)

⁸⁶ 'Evidence of the Royal College of Psychiatrists to the Royal Commission on the National Health Service' (Draft) (c.1976) 5 (PJ)

⁸⁷ DHSS, *Better Services for the Mentally Ill* Cmnd. 6233 (London: HMSO, 1975) iv

⁸⁸ GPOA, minutes, 10.10.1973, 2.b.v. (RCPsychA); Anon. 'Labour attack 'savage' NHS cuts' *Times*, 29.1.1974, 7

⁸⁹ P Hewitt, *Age Concern on Pensioner Incomes* (London: Age Concern, 1974) Cited in: Paul Brearley, 'Social gerontology and social work' *BJSW* (1976) 6: 433-447 436; B Seebom Rowntree, *Poverty and Progress: a second social survey of York* (London: Longmans, Green and Co, 1941) 296

Primarily, poverty in old age was related to socio-economic and occupational circumstances earlier in life, but, as before the welfare state, deprivation worsened in old age for those without independent incomes.⁹⁰ In the 1970s and 1980s, public concern about older people focussed on poverty, pensions and employment rights, much less on inequalities in health and social care.⁹¹

Robert Edwards, a Labour MP, put a Private Member's Bill to parliament in 1971, to 'create a public department with special responsibilities for advising and assisting elderly persons', including with health matters.⁹² It did not become law. The same year, Julian Tudor Hart, a GP, coined the expression 'inverse care law', indicating that the availability of good medical care varied inversely with the need for it in the population served.⁹³ He cited a BMA report:

any claim that the NHS has achieved its aim of providing equality in medical care is an illusion ... The motives for suggesting otherwise are political ...⁹⁴

The Royal Commission on the NHS in 1979 recommended additional resources for community care for older people, people with mental illness and mental handicap.⁹⁵ For older people, its recommendations were couched negatively in terms of 'the immense burden these demands would impose',⁹⁶ a reiterated defeatist sentiment⁹⁷ likely to discourage provision.

⁹⁰ Hubert Llewellyn Smith, *The New Survey of London Life and Labour* Vol. 3 (London: PS King and Son, 1932) 188; Rowntree, *Poverty and Progress*, 156, 290, 457; DHSS, *Inequalities*, 124-125

⁹¹ Thane, 'Older people and equality' 14-16

⁹² Robert Edwards, 'Care of the Elderly' HC Deb 4.5.1971 *Hansard* Vol. 816 cc1178-9 1178 <http://hansard.millbanksystems.com/commons/1971/may/04/care-of-the-elderly> accessed 22.9.2012

⁹³ Julian Tudor Hart, 'The inverse care law' *Lancet* (1971) 297: 405-412 405

⁹⁴ BMA, *Report of the Advisory Panel of the BMA on Health Services Financing* (London: BMA, 1970) Cited in: Hart 'Inverse care law' 412

⁹⁵ *Report of Royal Commission on the NHS*, 61

⁹⁶ *Ibid.* 358

⁹⁷ e.g. Rowntree, *Old People*, 2; Webster, *Political History*, 32-33

The Black Report (1980) on health inequalities restated that poorer socio-economic circumstances were associated with poorer health.⁹⁸ Thirty *per cent* of people past retirement age were estimated to be living at or below supplementary benefits levels.⁹⁹ Malnutrition found in 7% of a sample of older people also suggested significant poverty.¹⁰⁰ The Black Report commented that previous policies for community care had given older people a ‘poor deal’,¹⁰¹ and recommended appropriate housing, social and domiciliary support to assist them to live as independently as possible.¹⁰² The report was suppressed by the government. Only 260 duplicated copies were produced. A few were sent to journalists the day before August Bank Holiday weekend, guaranteeing lack of publicity.¹⁰³ There was no press release. Patrick Jenkin, Secretary of State for Social Services wrote in the foreword: ‘I am making the report available for discussion, but without any commitment by the government to its proposals’, the cost would be ‘quite unrealistic’.¹⁰⁴ Six years later, a follow-up report, *The Health Divide*, commissioned by the Health Education Council¹⁰⁵ (an independent body, mainly government funded) indicated lack of progress in remedying social and health inequalities. Like the Black Report, it made little impact. NHS resources were not yet allocated with reference to socio-economic deprivation, which affected many sectors of the population, including older people¹⁰⁶ and undermined provision of potentially effective services for them. Psychiatrists commented that the 1980s was ‘littered with a

⁹⁸ DHSS, *Inequalities in Health: report of a research working group* (Black Report) 1980. In: *Inequalities in Health: The Black Report* ed. Peter Townsend, Nick Davidson (Harmondsworth: Penguin Books, 1992)

⁹⁹ BMA, Board of Science and Education, *All our Tomorrows: growing old in Britain* (London: BMA, 1986) 2: citing DHSS, *Social Security Statistics 1984* (HMSO: Government Statistical Services, 1984)

¹⁰⁰ DHSS, *Inequalities*, 125

¹⁰¹ *Ibid.* 149

¹⁰² *Ibid.* 204

¹⁰³ Anon. ‘Inequalities in health’ *Lancet* (1980) ii: 513; Peter Townsend, Margaret Whitehead, Nick Davidson, ‘Introduction’ 1-27. In: *Inequalities* ed. Townsend and Davidson, 3-4

¹⁰⁴ Patrick Jenkin (Secretary of State for Social Services), ‘Foreword’ In: DHSS, *Inequalities*

¹⁰⁵ Margaret Whitehead, *The Health Divide*, 221-437. In: *Inequalities* ed. Townsend and Davidson, 221

¹⁰⁶ DHSS, *Review of the Resource Allocation Working Party Formula: final report by the NHS Management Board* (London: DHSS, 1988) 1.11.i, 2.31-2.41

plethora of failed reports', some of which were 'strangled at birth',¹⁰⁷ including the Black Report and *The Health Divide*.

As well as discarding the reports on inequalities, balanced economic analyses of NHS efficiency and effectiveness concerning older people seemed lacking. The average annual cost of health care for an individual in the UK in the early 1980s was estimated at £145 for ages 16-64 years, £455 for 65-74 years, and £1,160 for over 75s. Forty-three *per cent* of total health expenditure was on people over 65.¹⁰⁸ On first sight there appears to be a direct relationship between expenditure and chronological age, but this has been described as a political red herring.¹⁰⁹ Broad age bands concealed significant differences of health costs within them. They did not reveal the proportion of the total spent on maintaining health, usually at low cost, in an often lengthy period after retirement, and that spent at the very end of life. Meticulous, humane and often costly terminal care may be required at any age and is not a direct consequence of longevity. If anything, many chronic and life-limiting single organ diseases have higher investigative, treatment and care costs and may have a longer period of survival and dependency in younger rather than older people as other organ systems are more robust.

The DHSS attributed rising health costs to technology and to demands on acute hospital services, largely by more older people using health services, emphasising with italics, that '*they stay in hospital longer than younger people*'.¹¹⁰ Other factors likely to contribute significantly to health expenditure were hardly considered, including NHS staff salaries; demands for high-tech medication and services; expectations of society for good health; terminal illness at any age. Chronic illness in old age inevitably created some costs, but

¹⁰⁷ DI Khoosal, PH Jones, 'Community care again: a need for definition' *JRSM* (1989) 82: 451-452 451

¹⁰⁸ Nick Bosanquet, 'Public expenditure rules and the NHS' (CHE, 1985) 3, 4
<http://www.york.ac.uk/che/publications/in-house/archive/1980s/> accessed 24.12.2010

¹⁰⁹ Meena Seshamani, Alastair Gray, 'Ageing and health-care expenditure: the red herring argument revisited' *Health Economics* (2004) 13: 303-314; Brigitte Dormont *et al.* 'Health expenditure growth: reassessing the threat of ageing' *Health Economics* (2006) 15: 947-963

¹¹⁰ DHSS, *Health Care and its Costs: the development of the National Health Service in England* (London: HMSO, 1983) Preface, 12, 15

most conditions, such as dementia, could be managed relatively cheaply until within two to three years of death. Economic arguments also largely disregarded the fact that, despite common chronic health impairments, for example osteoarthritis, diabetes, cardio-vascular or respiratory conditions, or even the early stages of dementia, many retired people continued to contribute in practical and economic ways to their family and to society.¹¹¹

The increasing frequency and duration of the ‘rectangular curve’ of longevity, was described by James Fries in 1980 in the *New England Journal of Medicine*, one of the world’s most prestigious medical journals. It demonstrated a prolonged and healthy life for more people, with a ‘compression of morbidity’ and rapid decline in very old age.¹¹² This should have created a celebration of longevity, and pointed away from older people’s excessive use of health resources. However, this model was virtually absent from NHS economic analyses. More attention has been paid to Fries’ work since the 1980s: in 2002, WHO referred to it as ‘ground-breaking’ and described his paper as a ‘public health classic’.¹¹³

The cost of community care

The government worked on the premise that ‘community care’ would be cheaper than care in hospitals. This was reflected in the Green Paper *Priorities for Health and Personal Services* in 1976.¹¹⁴ The cost-cutting assertion was questioned by the RCPsych: ‘money, staff and resources saved by closing an in-patient ward are not sufficient for running a similar-sized unit for equivalent patients in the community’.¹¹⁵ The Royal Commission on the NHS

¹¹¹ Nicholas Coni, William Davison, Stephen Webster, *Ageing: the facts* (Oxford: OUP, 1984) vii-viii, 13-18; Thane, *Old Age*, 489-493

¹¹² James Fries, ‘Aging, natural death and the compression of morbidity’ *New England Journal of Medicine* (1980) 303: 130-135 130

¹¹³ Alexandre Kalashe, Isabella Aboderin, Irene Hoskins, ‘Compression of morbidity and active ageing: key priorities for public health policy in the 21st century’ *Bulletin of the World Health Organisation* (2002) 80: 243-244

¹¹⁴ DHSS, *Priorities for Health and Personal Social Services in England: a consultative document* (London: HMSO, 1976) 2, 40-42

¹¹⁵ RCPsych, ‘Comment on the consultative documents *Priorities for Health and Personal Services in England* and *Joint Care Planning: Health and Local Authorities*’ *NN* (Aug. 1976) 3-9 7

acknowledged the difficulties of evaluating services provided in different locations.¹¹⁶ Estimates of cost varied and were difficult to ascertain, partly due to the differing needs of patients requiring care, as well as the design of the evaluation studies. For example, older people, especially with dementia, who were physically frail and required supervision to prevent accidental harm, might cost more in the community where there were fewer economies of scale: one person could observe many older people in a Nightingale ward, but far fewer in their own homes or in care homes with single rooms. The timing of studies might also have been significant; a study undertaken while someone was settling into the community might have found higher costs than when they were more established.

Resources necessary to provide services for older people appeared unlikely to be allocated. In the context of an increasing older population, and annual inflation between 16% and 24% in the mid-1970s, the proposed 4% rise in expenditure on personal social services and 2.6% on health¹¹⁷ effectively decreased funding. A first draft of a DHSS planning statement for older people in 1976/7 acknowledged service reductions:

it is not possible to formulate a rational plan for service development in a situation of no expansion in overall resources. All that can be said unequivocally is that a static level of overall service provision for old people during the next 5 or 10 years represents, in fact, a diminution in services.¹¹⁸

In the fourth draft, the passage was modified to a more publicly acceptable statement still conveying the government's intention: 'If there were no change in the volume of resources ... there would be a marked decrease in the level of provision'.¹¹⁹ Another confidential report on public expenditure prepared for the Cabinet in 1977 was more obviously dismissive of the needs of older people: it stated that proposed funding would allow for adequate support for

¹¹⁶ *Report of the Royal Commission on the NHS*, 58

¹¹⁷ DHSS, *Priorities*, 1

¹¹⁸ DHSS, 'Group planning statement 1976/7: Group 7 – the elderly' First draft, 4 (TNA, MH 154/985)

¹¹⁹ *Ibid.* Fourth draft, 29 (TNA, MH 154/985)

children's services, but would not 'maintain standards' for social care for people over 75.¹²⁰ Beveridge in 1942 had cautioned against being 'lavish to old age until adequate provision has been made for all other vital needs'.¹²¹ Agate expressed fears in 1969 about older and younger people competing for resources.¹²² Using chronological age to ration care seemed even more explicit in 1976/7.

In 1977/8 the Cabinet acknowledged¹²³ that 'Important needs are going unmet' and standards of medical care for all age groups compared unfavourably with those in other industrial countries.¹²⁴ Standards had dropped in health and social care, especially for people with chronic illness or disability, including older people.¹²⁵

Policies: *A Happier Old Age and Growing Older*

In 1978, there was a theoretical change of heart towards older people with the Green Paper, *A Happier Old Age*.¹²⁶ Despite, predictably, restating the need for collaboration to make the best use of resources and increase effectiveness,¹²⁷ it also acknowledged that services were 'often less than satisfactory, making effective treatment or care difficult'.¹²⁸ It declared, in an enlightened way, that 'Old people must be able to take their own decisions about their own lives ... [and have] the fullest possible choice and a major say in decisions that affect

¹²⁰ Public Expenditure Survey Committee, part 2, 'Detailed Analysis of Programmes and Supplementary Analyses' Cabinet Papers, 4.7.1977, 109 (TNA, CAB 129/197/3)

¹²¹ Beveridge, *Social Insurance*, 92

¹²² Agate, 'Hospitals and community care' 39

¹²³ Public Expenditure Survey Committee, 'Detailed Analysis' 111 (TNA, CAB 129/197/3)

¹²⁴ Home Office, 'Expenditure on the National Health Service' Cabinet Report CP(78)28, 2.3.1978, Annex 2 (TNA, CAB 129/200/3)

¹²⁵ Home Office, 'Expenditure' 1-3 (TNA, CAB 129/200/3)

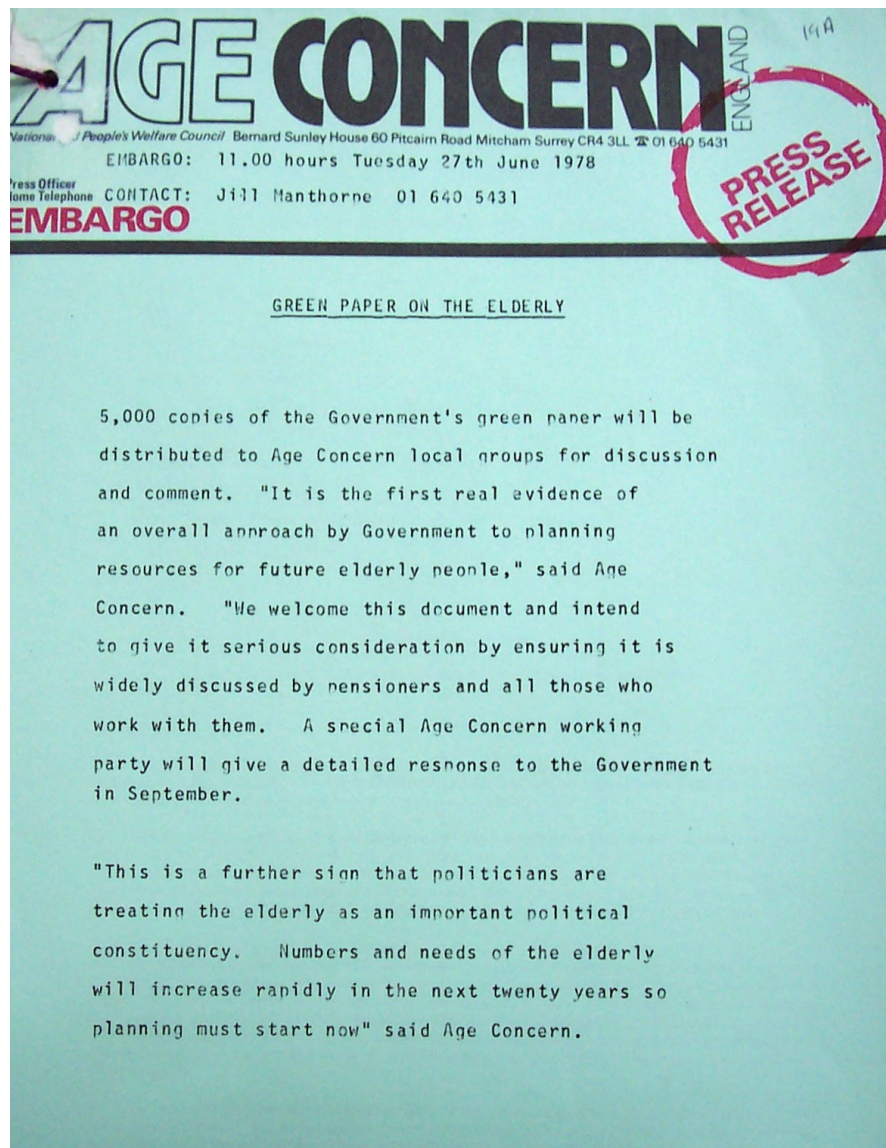
¹²⁶ DHSS, *A Happier Old Age: a discussion document on elderly people in our society* (London: HMSO, 1978)

¹²⁷ DHSS, *Happier Old Age*, 40-42, 44

¹²⁸ *Ibid.* 41

them'.¹²⁹ *A Happier Old Age* was well received by health and social care experts¹³⁰ (Fig 14).

Fig 14. Age Concern's press release welcoming *A Happier Old Age*, 1978



Source: National Archives (MH 154/1070) (Reproduced with permission from Age UK)

The sentiments of *A Happier Old Age* were honourable and important, but humane statements had not created better provision in earlier decades. The SPOA responded with comments, which, in the light of experience, appeared

¹²⁹ John Morris, David Ennals, Stanley Orme, 'Foreword' 4-6. In: DHSS, *Happier Old Age*, 5

¹³⁰ e.g. MIND, *Mental Health of Elderly People – MIND's response to the DHSS discussion Paper 'A Happier Old Age'* (London: MIND, 1979); Tony (Anthony) Whitehead, *A Ripe Old Age* (London: MIND, 1979)

obvious to them. These included basing future plans on the experiences of existing psychogeriatric services rather than on estimates; providing a variety of facilities to enable real choice; and providing appropriate training and salaries for residential home care staff. They also proposed correlating service specifications for dementia with the population aged over 75.¹³¹ Population change and the incidence of dementia were unequal across the different age bands¹³² so basing services on the total over 65 would conceal the amount of provision needed for the predictable, and proportionately greatest, increase in the ‘oldest old’.

Colin Godber, a psychogeriatrician in Southampton, commented on the ‘uncertain blandness’ of *A Happier Old Age*, and contrasted it with ‘forthright, provocative and, at times, dogmatic’ practical recommendations from MIND.¹³³ MIND emphasised that since older people, even with mental illness, usually lived in the community, community services rather than institutional care should be provided. The *Lancet* reported: ‘MIND urges the Government to introduce legislation compelling social-services departments to provide an early assessment and intervention service’ in collaboration with the NHS and voluntary bodies.¹³⁴ MIND’s suggestion of mandatory provision was reasonable; obligatory directives had influenced service development in other unpopular fields, such as for STDs.¹³⁵ Psychogeriatric illnesses were not physically infectious so were not associated with the same fears as STDs, but perhaps the younger ages of most people affected by STDs contributed to the government’s approach to providing those dedicated, expert services. The unpopularity of working with older people and the need for services for them were recognised, but the government did not enforce provision.

¹³¹ RCPsych, ‘*A Happier Old Age*: The College’s comments’ *Psychiatric Bulletin* (1979) 3: 85-87 86-87

¹³² DHSS, *Happier Old Age*, 8

¹³³ Colin Godber, ‘Mental health of elderly people - MIND’s response to the DHSS discussion paper *A Happier Old Age* (MIND, 1979)’ *Psychiatric Bulletin* (1979) 3: 139

¹³⁴ Anon. ‘Mental health of elderly people’ *Lancet* (1979) i: 395. Report based on Alison Wertheimer, *Mental Health of Elderly People: MIND’s response to the DHSS discussion paper ‘A Happier Old Age’* (London: MIND, 1979)

¹³⁵ Weisz, *Divide and Conquer*: 216-217; Willcox, ‘Fifty years’ 9

The Labour government planned to produce a White Paper the following year¹³⁶ but the change in government prevented it. *Growing Older*,¹³⁷ the Conservative government's response was published in March 1981.¹³⁸ Drafts circulated in various government departments from at least June 1980.¹³⁹ There was significant opposition to it, including from the Treasury. Peter Kemp, Under Secretary at the Treasury, commented in an internal memo: 'More emphasis is needed on voluntary effort and less on public expenditure',¹⁴⁰ but recognised that saying this publicly might 'expose Ministers to the charge of being "uncaring"'.¹⁴¹ The Treasury also advised that the section 'covering the quality of life in hospitals and psychiatric provision, could be pruned'.¹⁴² Priorities were clear in *Growing Older*:

As the economy improves, elderly people will share in that improvement. In the meantime, we have to hold back on public spending and concentrate on the revival of the economy.¹⁴³

Overall, *Growing Older* shifted little from previous plans. For psychogeriatrics, it reiterated earlier ideas, including appointing a consultant 'with a special interest' in each district,¹⁴⁴ adequate DGH assessment facilities¹⁴⁵ and long-stay facilities close to home.¹⁴⁶ It acknowledged that health services should be equitable in quality and quantity with those for younger people. Contradictorily, it stated that family, neighbours and friends, and voluntary and

¹³⁶ DHSS, 'Draft parliamentary question to announce publication of discussion document' and 'suggested reply' (TNA, MH 154/1069)

¹³⁷ DHSS, *Growing Older* Cmnd. 8173 (London: HMSO, 1981)

¹³⁸ JS Rogers, 'Growing older but not happier' *Lancet* (1981) ii: 84-85 84

¹³⁹ E Peter Kemp (Treasury) to S Scott Whyte (DHSS), letter, 26.6.1980 (TNA, HLG 118/2846)

¹⁴⁰ Attached to letter from Kemp, 26.6.1980: 'White Paper on the elderly. Points on the draft text raised by the Treasury', 1 (TNA, HLG 118/2846)

¹⁴¹ E Peter Kemp (Treasury) to S Scott Whyte (DHSS), letter, 26.6.1980 (TNA, HLG 118/2846)

¹⁴² Attached to letter from Kemp, 26.6.1980: 'White Paper on the elderly. Points on the draft text raised by the Treasury', 2 (TNA, HLG 118/2846)

¹⁴³ Patrick Jenkin *et al.* 'Foreword' iii-iv. In: DHSS, *Growing Older*, iii

¹⁴⁴ BMA, *Care and Treatment*, 22-23; DHSS, HM (72)71, 6

¹⁴⁵ McKeown, *Medicine in Modern Society*, 115-126

¹⁴⁶ BMA, *Care and Treatment*, 22-23; DHSS, *Growing Older*, 54-57

religious organisations would be central to providing care and supporting older people, without demonstrating how this could produce equitable services,¹⁴⁷ and that

The increasing needs of increasing numbers of older people simply cannot be met wholly – or even predominantly by public authorities or public finance.¹⁴⁸

This attitude to providing comprehensive services was not intended to promote their development. Written answers to the House of Commons reinforced this view: *Growing Older* was ‘intended to provide a stimulus to thought and action throughout the community’.¹⁴⁹ Nevertheless, it stated: ‘Voluntary bodies and private individuals offering help should be able to rely on the wholehearted support of the public services’.¹⁵⁰ Combined with the 1982 NHS reorganisation, which emphasised the delegation of responsibility for health care provision from the DHSS to new District Health Authorities,¹⁵¹ the SPOA commented: ‘Whilst some will find all this bracing many will feel a chill wind blowing – particularly those perhaps in the statutory services’.¹⁵²

Before publication of *Growing Older*, Kemp stated: ‘it would save a great deal of time on all our parts if Ministers could agree now, without further ado, that the idea of this White Paper should be dropped’.¹⁵³ After publication, JS Rogers, a community physician, described *Growing Older* as ‘a sad affair ... It might have been better to have forgotten the whole thing, rather than churn out such an uninspiring paper after three years’.¹⁵⁴

¹⁴⁷ DHSS, *Growing Older*, iii, 60, 64

¹⁴⁸ *Ibid.* 59

¹⁴⁹ George Young, ‘Growing Older’ HC Deb 31.3.1981 *Hansard* Vol. 2 c71W http://hansard.millbanksystems.com/written_answers/1981/mar/31/growing-older accessed 30.9.2012

¹⁵⁰ DHSS, *Growing Older*, 60

¹⁵¹ DHSS, *Patients First* (London: HMSO, 1979); DHSS, *Care in Action* (London: HMSO, 1981)

¹⁵² SPOA, ‘Commentary on the DHSS publications “Growing Older” and “Care in Action”’ 24.9.1981 (TA)

¹⁵³ E Peter Kemp (Treasury) to S Scott Whyte (DHSS), letter, 26.6.1980 (TNA, HLG 118/2846)

¹⁵⁴ Rogers, ‘Growing Older’ 85

There was a limit to how long the neediest old people could wait for improvements. Many older people had paid taxes and contributed to National Insurance since 1948. They believed they had pre-paid for their health care, but it was not being provided, despite Labour acknowledging in 1978 that ‘they have made their contribution to the prosperity and stability of our society ... and society owes a debt to them for their past efforts’.¹⁵⁵ Most disconcertingly, *Growing Older* stated that ‘secure, dignified and fulfilled lives in their later years ... It will never be possible to achieve it for everyone’.¹⁵⁶ This was contrary to the United Nations Universal Declaration of Human Rights (1948), for which the UK voted, and the European Convention on Human Rights (1953), which the UK signed. The United Nations World Assembly on Ageing in 1982, a political rather than a medical conference, exhorted governments to set short, medium and long-term objectives and considered it necessary to emphasise that the Universal Declaration applied ‘fully and undiminishedly’ to older people.¹⁵⁷ In 1986, the King’s Fund voiced their concern, emphasising that people with dementia have the same human rights and individual needs as anyone, irrespective of their degree of disability, plus the right to support which does not exploit family and friends.¹⁵⁸

Funding older people’s health care under the Conservative government

The Conservative Party came into office in 1979 committed to controlling inflation which had been increasing rapidly internationally. Also, many Western countries experienced rising costs of health care as a percentage of GDP, reflected in the data collected by the Organisation for Economic Co-operation and Development,¹⁵⁹ although the UK NHS was relatively cost

¹⁵⁵ Morris, In: *Happier Old Age*, 4

¹⁵⁶ DHSS, *Growing Older*, 64

¹⁵⁷ United Nations, *Vienna International Plan of Action on Aging* (New York: UN, 1983) 9

¹⁵⁸ King's Fund Centre, *Living Well into Old Age: applying principles of good practice to services for people with dementia* (London: King's Fund Centre, 1986) 24-25

¹⁵⁹ Organisation for Economic Co-operation and Development (OECD), *Public Expenditure on Health* (OECD Studies on Resource Allocation no. 4) (Paris: OECD, 1977)

effective.¹⁶⁰ Margaret Thatcher directly linked an ageing society to an economic ‘time bomb’ of welfare expenditure. Although not all her cabinet or the DHSS were reported to agree with her,¹⁶¹ such statements discouraged dispassionate consideration of expenditure on older people’s care.

The Conservative election manifesto emphasised that good standards of welfare depended on a prosperous economy, not on the state spending more of the nation’s wealth. It also emphasised the role of the community: ‘we must do more to help people to help themselves, and families to look after their own’.¹⁶² Assuming that everyone could ‘look after their own’ was unrealistic; most families were already doing their best, some older people had no family and some people were unable to offer care, for health, financial, social or psychological reasons. In 1961, 19% of people over 65 in the UK were living alone, and in 1981, 30%,¹⁶³ at least partly because of a desire for independence and wish to live in the family home. There is no evidence that living alone indicated neglect, or lack of close contact with family and friends.¹⁶⁴

In 1981, the DHSS’s *Care in the Community* was subtitled *A consultative document on moving resources for care*, its real objective.¹⁶⁵ It reinforced the need for health and social services collaboration, and, characteristically, stated that progress depended on making better use of what was already available, including in the voluntary and private sectors.¹⁶⁶ ‘Moving resources’ was a problem. Funds should have been available from psychiatric hospital closures planned since 1961. However, by 1983 not a single hospital had closed

¹⁶⁰ George Schieber *et al.* ‘Health system performance in OECD countries, 1980-1992’ *Health Affairs* (1994) 13: 100-112 101

¹⁶¹ David Walker, ‘Thatcher floats her fears of benefits “time bomb”’ *Times*, 25.1.1984, 5

¹⁶² Conservative Party, *General Election Manifesto* (1979) ‘Our Five Tasks’ ‘Helping the Family’ <http://www.conservative-party.net/manifestos/1979/1979-conservative-manifesto.shtml> accessed 28.5.2011

¹⁶³ Melanie Henwood, Malcolm Wicks, *The Forgotten Army: family care and elderly people* (London: Family Policy Studies Centre, 1984) 5-6

¹⁶⁴ Thane, *Old Age*, 428-431

¹⁶⁵ DHSS, *Care in the Community: a consultative document on moving resources for care in England* (1981)

¹⁶⁶ *Ibid.* 1-2, 4-5

completely.¹⁶⁷ Partially closed institutions were unlikely to provide sufficient resources for community care, because ongoing maintenance of old buildings was costly and, when wards closed, nurses were transferred to other overcrowded and understaffed wards rather than to the community. Some authorities were reluctant to transfer NHS finances. The DHSS acknowledged that what might have been available was diminished by ‘obstacles, legal and otherwise’¹⁶⁸ and a House of Commons Select Committee noted ‘excuses as well as reasons for lack of action’.¹⁶⁹ Failure to transfer funds increased dependence on the voluntary and private sectors to provide community care, and potentially further removed responsibility from, and demands on, statutory services. So-called ‘joint funding’, transferred from health to social services to enable discharge from psychiatric hospitals, was a temporary ‘meal ticket’¹⁷⁰ which accompanied an individual, with the hope that, ultimately, community care would be cheaper, or ‘at least be no more expensive’, than hospitals,¹⁷¹ an assertion which was still unproven.¹⁷²

Funding of community services for mental health was a major concern to the National Association of Health Authorities¹⁷³ and to psychogeriatricians.¹⁷⁴ The DHSS had no intention of providing it indefinitely:

Central funding would be inconsistent with the government’s determination to see that the responsibility for providing services rests where it belongs, at local level.¹⁷⁵

¹⁶⁷ Ramon, *Meaning and Policy*, 2, citing South West Thames RHA, *The Future Pattern of Services for the Mentally Ill*, 8

¹⁶⁸ DHSS, *Care in the Community*, 6

¹⁶⁹ HC Social Services Select Committee, *Community Care*, lvix

¹⁷⁰ DHSS, ‘Breaking down the barriers’ memo (c.Sept. 1980) 2 (TNA, MH 154/1376)

¹⁷¹ DHSS, ‘*Care in the Community*: briefing for press conference’ Draft 2 (1982) (TNA, MH 154/1562)

¹⁷² DHSS, *Care in the Community*, 3

¹⁷³ Anon. ‘Mentally ill: more resources needed’ *BMJ* (1980) ii: 1228

¹⁷⁴ Whitehead, ‘Closing large mental hospitals’; John Kellett, ‘Resources for dementia’ *Times*, 26.8.1982, 9

¹⁷⁵ Secretary of State’s meeting with chairmen and directors of social services, 25.7.1979; ‘Run down of large psychiatric hospitals’, draft speaking note (TNA, MH 154/1376)

The ‘mental hospitals’, Whitehead commented, risked becoming ‘depositories for the elderly, who will receive very little treatment and not a lot of support’.¹⁷⁶ *Care in the Community* addressed the needs of older and mentally handicapped people, but, of the two, proposed that the latter, ‘whose needs for care are most easily predictable’,¹⁷⁷ were dealt with first, again relegating older people to second place.

There is some evidence, in the early 1980s, that old age health care did not receive its due allocation of funding. Health economist Nick Bosanquet commented that, due to the increasing numbers of people over 75, additional funding of £220 million (at 1982/3 prices) was needed to provide ‘age sensitive services’ but only £116 million was used for that purpose. He commented: ‘allowance for the actual costs of aging should actually be spent on those services’.¹⁷⁸ For personal social services, expenditure on local authority age-sensitive services only increased at half the rate of other services,¹⁷⁹ inadequate considering demographic changes.

Rising costs of health care were attributed to remediable inefficiency within the NHS,¹⁸⁰ and the government again tried reorganising the NHS to reduce them. The 1982 reorganisation¹⁸¹ hardly had time to become established before another followed two years later, a new management system based on the commercial sector. Sir Roy Griffiths, managing director of the supermarket chain J. Sainsbury Plc, was appointed by the government to review NHS management. Griffiths introduced ‘general management’ with ‘the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance’.¹⁸² The

¹⁷⁶ Whitehead, ‘Closing large mental hospitals’ 1140

¹⁷⁷ DHSS, *Care in the Community*, 13

¹⁷⁸ Bosanquet, ‘Public expenditure’ 1

¹⁷⁹ *Ibid.* 8

¹⁸⁰ *Ibid.* 1-2, 4-5

¹⁸¹ DHSS, *Care in Action*

¹⁸² Roy Griffiths, *National Health Service Management Inquiry Report* (London: HMSO, 1983) 11

‘one person’ was a professional manager. General management was implemented concurrently with NHS decentralisation; managers at all levels had greater authority on service planning, doctors less. The DHSS was reluctant to create old age services,¹⁸³ but delegation to local authorities seemed to some commentators on health policy synonymous with a central ‘abdication of responsibility’.¹⁸⁴ Unless local managers had an interest in older people, undervalued old age specialties were unlikely to receive sufficient priority. Griffiths’ plans provoked widespread concern among health service staff, including psychogeriatricians.¹⁸⁵

Community alternatives to long-stay hospital care in the 1980s

Community care for people with mental illness and mental handicap, whether older or younger, was subject to similar difficulties: patients were ‘dumped into a no-man’s-land of scarcely existent’ resources, according to social activist Peter Sedgewick.¹⁸⁶ Care for people with physical disabilities was similar.¹⁸⁷ Government ideals for care were shifting from funding and provision by statutory services *in* the community, to unfunded provision *by* the community.

Providing long-stay care was a major funding concern for the government. However, following the argument of the ‘rectangular curve’,¹⁸⁸ older people should have remained independent at home until later ages rather than becoming institutionalised longer. Data on institutional care seems to support this hypothesis. About 5% of people over 65 lived in institutions in the late 1970s,¹⁸⁹ a rate fairly constant over decades,¹⁹⁰ although estimates varied

¹⁸³ DHSS, *Growing Older*, 58

¹⁸⁴ RFA Shegog, ‘Conclusions’ 7-26. In: *The Impending Crisis of Old Age: a challenge to ingenuity* ed. RFA Shegog (Oxford: OUP, 1981) 8

¹⁸⁵ SPOA, minutes, 1.12.1983, 39EC/83 (RCPsychA); House of Commons Social Services Committee, *First report: Session 1983-4: Griffiths NHS Management Inquiry Report* (London: HMSO, 1984) vi-ix

¹⁸⁶ Peter Sedgewick, ‘The fate of psychiatry in the new populism’ *Psychiatric Bulletin* (1983) 7: 22-25 22

¹⁸⁷ Millar, ‘Disability’ 170

¹⁸⁸ Fries, ‘Aging, natural death’ 130

¹⁸⁹ M Clarke *et al.* ‘The elderly in residential care: patterns of disability’ *Health Trends* (1979) 11: 17-20 18

according to methodology.¹⁹¹ Mean age of residents increased.¹⁹² Duration of long-stay institutional care was harder to calculate, especially for the earlier years of this study, due to the cross-sectional nature of much official data and non-uniformity of statistics over a given period for the different types of institution (NHS psychiatric and geriatric, local authority, voluntary and private). However, in the 1980s, mean length of stay was around three years,¹⁹³ similar to 2000,¹⁹⁴ suggesting that duration of high-dependency requiring institutional care was not directly related to longevity. This fits with the complexity of decision making about moving into institutional care. This was influenced by factors other than health and frailty including stigma, marital status, changing preferences of older people, local availability of care homes, health of adult children and personal finances, such as home ownership in circumstances of means tested social care.¹⁹⁵ Regarding health and frailty, optimum treatment and support of people at home by community orientated psychogeriatric and geriatric services could potentially contribute to avoiding admission to long-stay care. Even small changes in average levels of dependency for a population would have sizable effects on demands for long-stay resources.¹⁹⁶ Nevertheless, services were not forthcoming.

In the 1980s, government policy supported the development of private, profit-making care homes for which state welfare benefits provided much of the funding. DHSS payments to private homes rose from £102 million in 1983, to £190 million in 1984.¹⁹⁷ Privatisation and free-market policies siphoned off

¹⁹⁰ M Bajekal, *Health Survey for England 2000: care homes and their residents* (London: TSO, 2002) 11; Rowntree, *Old People*, 95

¹⁹¹ Emily Grundy, Karen Glaser, 'Trends in, and transitions to, institutional residence among older people in England and Wales, 1971-91' *Journal of Epidemiology and Community Health* (1997) 51: 531-540

¹⁹² Anne Netten *et al.* 1996 *Survey of Care Homes for Elderly People* PSSRU discussion paper 1423/2 (1998) 43 www.pssru.ac.uk/pdf/dp1423-2.pdf accessed 14.3.2011

¹⁹³ *Ibid.* 44

¹⁹⁴ Bajekal, *Care homes and their residents*, 19

¹⁹⁵ Grundy and Glaser, 'Trends' 538-540

¹⁹⁶ Raphael Wittenberg *et al.* *Demand for Long-term Care: projections of long-term care finance for elderly people* (Kent: PSSRU, 1998) 117 www.pssru.ac.uk/pdf/lcrep98.pdf accessed 31.1.2013

¹⁹⁷ BMA, *All Our Tomorrows*, 17

public resources into private business. The Audit Commission, set up in 1983 to protect the public purse, labelled such ‘effects of social security policies’ as ‘perverse’.¹⁹⁸ In 1988, Gwynneth Dunwoody, a Labour MP, was critical, to no avail:

As a result of the pressure on the Health Service from an elderly and growing population requiring help, the NHS has almost become a system that decants units into suitable storage depots ... [P]eople are told that there are no NHS beds and that they must go into private care. But they cannot afford to pay the sum, even with income support or anything else with a fancy name for handing out charity.¹⁹⁹

Privatisation policies juxtaposed closing NHS beds which had psychogeriatric input and replacing them with private facilities without it.²⁰⁰ In addition, chronic illnesses previously treated free under the NHS were increasingly dealt with by local authority means tested social care.²⁰¹ Based on the philosophy of free health care in a universal NHS, that was unfair to people suffering from such illnesses.

The Audit Commission identified fundamental problems underlying the slow implementation of community care. These included insufficient finances, organisational fragmentation, ineffective joint working and inadequate training for staff previously working in long-stay hospitals. They concluded that radical steps, not fine tuning, were required.²⁰² Sir Roy Griffiths took this up in another Green Paper, *Community Care: agenda for action*. He was aware of the challenges:

many social services departments and voluntary groups grappling with the problems at local level certainly felt that the Israelites faced with the

¹⁹⁸ Audit Commission, *Making a Reality*, 43, 47

¹⁹⁹ Gwynneth Dunwoody, ‘Elderly People (Social Security System)’ HC Deb 24.8.1988 *Hansard* Vol. 134 cc300-306
http://hansard.millbanksystems.com/commons/1988/may/24/elderly-people-social-security-system#S6CV0134P0_19880524_HOC_530 accessed 13.10.2012

²⁰⁰ SPOA, minutes, 10.3.1988, 10EC/88 (RCPsychA)

²⁰¹ Elaine Murphy, ‘Griffiths on community care: potentially disastrous’ *BMJ* (1988) 296: 876-877 876

²⁰² Audit Commission, *Making a Reality*, 13

requirement to make bricks without straw had a comparatively routine and possible task.²⁰³

Despite recognising the implications of government under-resourcing, Griffiths did not criticise it, but clung to his terms of reference which emphasised making better use of current funds.²⁰⁴ He stated that community care was the responsibility of local authorities who should assess needs and arrange care, but private providers should be encouraged.²⁰⁵ This was in line with his commercial background and with wider changes in public service management, creating divisions between local authorities as service ‘enablers’ and the private sector as ‘providers’. Some psychogeriatricians welcomed some of Griffiths’ principles, such as individual assessment of need, clear accountability, targeting resources at the most needy, providing suitable domestic environments for care, and giving more voice and choice to consumers and their families.²⁰⁶ Murphy queried whether local authorities had the expertise or the will to manage the community care delegated to it, including approximately 20% of local health authority budgets.²⁰⁷ The RCPsych reiterated that the main obstacle to development over recent years was lack of funds.²⁰⁸ Other recommendations by Griffiths, including appointing a Minister of State responsible for community care and protecting community care budgets, were rejected by the government.²⁰⁹

The government’s response to Griffiths’ report was the NHS and Community Care Act 1990.²¹⁰ This was the statutory basis for extension of the purchaser-provider, quasi-market structure of the NHS. It also enshrined the roles of

²⁰³ Roy Griffiths, *Community Care: agenda for action* (London: HMSO, 1988) iii

²⁰⁴ *Ibid.* iii, iv

²⁰⁵ *Ibid.* vii

²⁰⁶ Elaine Murphy, ‘Government must act on community care’ *BMJ* (1988) 297: 1558-1559

²⁰⁷ Murphy, ‘Griffiths on community care’ 877

²⁰⁸ RCPsych, ‘Comments on the Griffiths Report: *Community Care: agenda for action*’ *Psychiatric Bulletin* (1988) 12: 385-388 386

²⁰⁹ Griffiths, *Community Care*, 17, 23; David Jolley, Tom Arie, ‘Developments in psychogeriatric services’ 117-135. In: *Recent Advances in Psychogeriatrics* 2. ed. Arie, 130

²¹⁰ National Health Service and Community Care Act 1990, chapter 19

social services in assessing need, while delegating care to the expanding private sector. Ideas and policies from the 1980s were carried forward into the 1990s.

Conclusions

Older people were not alone in experiencing health inequalities, but prioritisation of acute illness over chronic, high-tech approaches over psychosocial and younger people over older, particularly disadvantaged older people with persisting mental disorders. Economic constraints, and failure to incorporate new information into economic analyses, such as about longevity and increasing years of good health rather than dependency, suggests that the government lacked the will to provide for them. Defeatist statements regarding resourcing older people's services, such as by the Royal Commission on the NHS and in *Growing Older*, support this view. There is no evidence of exploration of whether adequate management of chronic disorders could improve health and therefore save money by reducing demands on expensive, acute services.

There were glimmers of hope for change, such as *A Happier Old Age* and the modernisation of psychiatry generally. However, for the new psychogeriatricians, the combined of lack of interest in and prioritisation of older people's needs, economic uncertainties and privatisation policies for 'social' care, created a particularly difficult climate in which to establish their specialty.

Chapter 5

Developing psychogeriatric services in the 1970s and 1980s

colleagues who argue that [psychogeriatrics] should not exist are in no stronger a position than Canute holding back the waves.

Professor Brice Pitt (1974)¹

Introduction

By the 1970s, fundamental psychogeriatric clinical principles were well established, based on work by pioneers in the 1940s and 1950s, including Warren, Cosin, Post, Lewis, Sheldon, Rowntree, Goldschmidt and Roth. Accurate diagnosis and effective medical, psychological and social treatments could help many people. Even for incurable organic disorders, managing symptoms and supporting carers could bring significant benefit. These principles have stood the test of time and remain fundamental to high quality clinical work. However, by 1970, they were not widely practiced.

Some of the earliest pioneers advocating for older mentally ill people were retiring, Lewis in 1966² and Cosin in 1976.³ Some had died, such as Warren in 1960⁴ and Macmillan in 1970.⁵ Sheldon died in 1972.⁶ Barton emigrated to America around 1970.⁷ Roth was elected first president of the RCPsych in 1971. He remained supportive of the GPOA,⁸ but usually at a distance.⁹ Appropriately, his commitment went mainly into developing the College. Of those working in the field before the 1960s, Post and Robinson remained committed to it.

¹ Brice Pitt, *Psychogeriatrics: an introduction to the psychiatry of old age* (Edinburgh: Churchill Livingstone, 1974) Preface

² Series, 'Lewis'

³ Irvine, 'Cosin'

⁴ Barton and Mulley, 'History and development' 230

⁵ HF, 'D Macmillan'

⁶ Barton and Mulley, 'History and development' 230

⁷ Gittins, *Madness*, 89

⁸ GPOA, minutes, 9.2.1973, 3 (RCPsychA)

⁹ Arie, e-mail, 2009

The voices of the early pioneers in psychogeriatrics continued in the *clinical* sense, but less in the *organisational* sense, which was relatively un-developed and with which this thesis is most concerned. The baton of leadership largely passed to those who had become psychogeriatric consultants in the 1960s, such as Arie, Pitt, Bergmann, Whitehead and Garry Blessed, supported by Post and Robinson.

The previous chapter explored some of the societal challenges faced by psychogeriatricians in developing their specialty. This chapter traces the route taken by the psychogeriatricians to create dedicated psychogeriatric services and the outcomes they achieved.

Psychogeriatricians: supporting each other

Around the time Arie made his DHSS debut, a ‘coffee house’ group of young consultant psychogeriatricians began to meet to exchange views and consider ways to improve their services.¹⁰ Until then, they were relatively isolated: ‘I got so lonely and we, all of us ... wanted to meet each other’, said Pitt.¹¹ Members included Loic Hemsli and James Cockburn (from Long Grove Hospital, Epsom), Carrick McDonald (from Warlingham Park Hospital, Surrey), Bergmann and Blessed (from Newcastle upon Tyne), Whitehead, Arie and Pitt¹² (Fig 15). This group had similar objectives to the Medical Society for the Care of the Elderly (MSCE, BGS) established by the geriatricians in 1947. It is surprising that psychogeriatrics had taken so much longer than its physical illness counterpart to reach the stage of forming a nucleus of interested consultants. The almost religious enthusiasm of the MSCE – ‘we were engaged upon a crusade on behalf of our forgotten but deserving patients’¹³ – resembled the fervour of the new psychogeriatricians: ‘a happy band of pilgrims’, as Pitt described them.¹⁴ The intense enthusiasm was described by

¹⁰ GPOA, minutes, 9.2.1973, 2 (RCPsychA)

¹¹ Pitt, ‘Witness’ 20

¹² Tom Arie, ‘Martin Roth and the “Psychogeriatricians”’ 231-238. In: *Contemporary Themes in Psychiatry: a tribute to Sir Martin Roth* ed. K Davidson, A Kerr (London: Gaskell, 1989) 233

¹³ Howell, ‘Origins’ 72

¹⁴ Pitt, interview by author (2006)

Arie in 1971: ‘I have never before been in a professional setting where intellectual and emotional satisfaction go more closely hand in hand’,¹⁵ with implications that treating mentally ill older people could be a rewarding career.

Fig 15. Psychogeriatric services in 1969 and places of work of psychiatrists attending the ‘coffee house’ group, 1971



Source: Arie, ‘Martin Roth and the “Psychogeriatricians”’, 233; *Medical Directory*, (London: JA Churchill, 1973). Map drawn by Jacob Hilton

The coffee house group realised that, if they were to make a significant impact, they would have to increase their numbers and acquire a body through which to have a voice. The required quorum for an official RCPsych Group was achieved and the GPOA was inaugurated on 9th February 1973.¹⁶ Its purpose (although not explicitly stated during the early meetings) was to promote good

¹⁵ Tom Arie, ‘Morale and the planning of psychogeriatric services’ *BMJ* (1971) iii: 166-170

¹⁶ GPOA, minutes, 9.2.1973, 2 (RCPsychA)

practice by sharing experiences, developing services, fostering education, encouraging research, exerting pressure on government and other bodies and commenting on all matters relating to mental health in old age.¹⁷ Post was elected chairman, and Pitt secretary.¹⁸ A dedicated group of around 30 members (Fig 16) met quarterly for the next five years. In 1975, Arie stated that the Group was the largest and most enthusiastic committee on which he sat.¹⁹ It formed links within the RCPsych and outside, including with policy makers, geriatricians, nurses and social workers, to develop age-appropriate services. The GPOA was the only national body campaigning for better services for older mentally ill people. Other organisations, for example, the Alzheimer's Disease Society (Alzheimer's Society since 1999) was founded in 1979,²⁰ while Age Concern (now Age UK) had no specific mental illness focus.

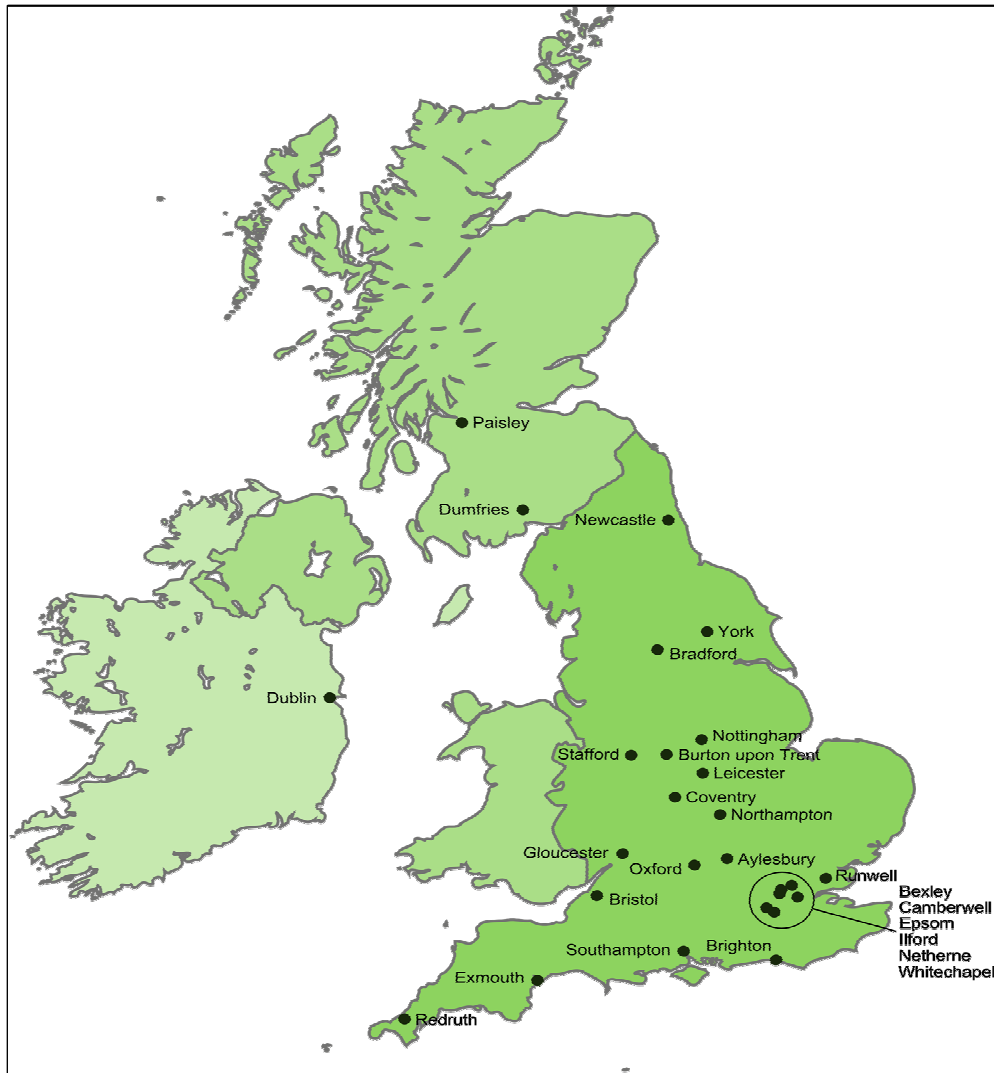
¹⁷ GPOA, 'Draft Memorandum on the readiness of the group for the Psychiatry of Old Age now to become a section of the Royal College of Psychiatrists' (c. Oct. 1977) (RCPsychA)

¹⁸ GPOA, minutes, 9.2.1973, 5 (RCPsychA)

¹⁹ GPOA, minutes, 30.1.1975, 'reminder notes' 6 (RCPsychA)

²⁰ Alzheimer's Society, 'Our History' http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=81 accessed 30.4.2013

Fig 16. Places of work of psychiatrists attending the first and third meetings of the GPOA, 1973



Source: Derived from GPOA minutes, 9.2.1973 and 10.10.1973, and *Medical Directory* 1973. Map drawn by Jacob Hilton

The GPOA faced significant intra-professional conflict, including the continued ambivalence of many psychiatrists towards older people, not wanting themselves to work with them, or, it seemed, others to do so. Some senior colleagues commented disparagingly on those who did.²¹ Arie reflected in 1973 that many doctors and social workers ‘cannot formulate a “psychogeriatric” problem in any other terms but as the need to get it instantly off their hands’.²² Bergmann commented that clinicians may ‘forget that their own attitudes may also have contributed to the present unsatisfactory

²¹ Robin Jacoby, autobiographical note, ‘Witness’ 100-102, 100

²² Tom Arie, ‘Dementia in the elderly: diagnosis and assessment’ *BMJ* (1973) iv: 540-543 541

situation',²³ and Whitehead stated that psychiatrists should stop 'pretending that the old were not their concern'.²⁴ In an interview, Pitt later commented:

We wanted to present a united front. We were pretty paranoid about general psychiatrists ... who were more likely to exploit than support us.²⁵

Ambivalence may have been aggravated by domiciliary visit fees and perceived threats to established working patterns and resources.²⁶

The voice of the GPOA was not always heard by the DHSS or within the RCPsych. Jolley commented that the DHSS listened to the Group,²⁷ but at times it did 'not quite' understand its concerns, such as about reports of poor clinical care of older people.²⁸ A senior DHSS representative usually attended GPOA meetings,²⁹ so overt criticism may have risked harming that relationship.³⁰ As the GPOA grew, the logical way to increase recognition was for it to become a Section. This had the advantage of automatic representation on the College Council, important because sometimes the GPOA found Council unsupportive.³¹

Representation was temporarily achieved when Post was elected to Council in 1975.³² That year, GPOA membership was still closer to 100 than the 500 required for Section status.³³ Morris Markowe, Dean of the College, advised the GPOA on an alternative plan: they should have an executive committee to

²³ Bergmann, 'Psychogeriatric services' 7

²⁴ J Anthony (Tony) Whitehead, 'Now tell us how to solve the psychogeriatric problem of the psychiatric hospitals' *NN* (Aug. 1972) 4-5 5

²⁵ Pitt, interview by author (2006)

²⁶ Pitt, 'Witness' 18

²⁷ Jolley, e-mail, 18.5.2007

²⁸ GPOA, minutes, 6.5.1976, 7.i. (RCPsychA)

²⁹ GPOA, meeting attendance lists (RCPsychA)

³⁰ GPOA, minutes, 10.10.1973, 2.a.v. (RCPsychA)

³¹ Jolley to Pitt, letter, 8.4.1977 (PJ)

³² Anon. 'Election for elected members of Council' *NN* (Dec. 1975) 2

³³ Markowe to Pitt, letter, 30.1.1975 (PJ)

prepare comments for submission to Council between meetings, for, by relying on quarterly meetings, they were not making any real impact as a pressure group.³⁴ It is difficult to know to what extent the lack of impact was due to the Group's organisation, or to others not listening, but if Markowe's advice was correct, it is regrettable that it took three years for the point to be made. 'Section' status, achieved in 1978, was important, but was not automatically associated with increased understanding by influential bodies or with DHSS recognition which might facilitate service provision.

A blueprint for development: implications and aftermath

The DHSS memorandum *Hospital Services for the Mentally Ill* published in 1971³⁵ mentioned 'psycho-geriatric' assessment facilities and 'a well developed geriatric department', but noted that 'This memorandum does not deal with services for elderly patients whose mental illness symptoms are the result of ageing or physical disease or both'. It promised further guidance.³⁶ MIND and the RCPsych were disappointed that older people were virtually excluded.³⁷ It resembled Boucher's report in 1957 which excluded older people's mental health from a survey of geriatric facilities. These exclusions indicated that neither psychiatric nor geriatric services automatically accepted responsibility for providing health services for mentally ill older people.

In 1970, a group of geriatricians and psychiatrists, advised by Amulree under the auspices of the Society of Clinical Psychiatrists (an independent organisation founded to enhance psychiatrists' clinical freedom³⁸) proposed widespread, comprehensive psychogeriatric services.³⁹ Their proposals concurred with those of the coffee house group which in 1972 'heavily

³⁴ GPOA, minutes, 6.5.1976, 5.a. (RCPsychA)

³⁵ DHSS, *Hospital Services*

³⁶ *Ibid.* 1

³⁷ MIND, *Now Tell Us How to Solve the Psychogeriatric Problem of the Psychiatric Hospitals* (London: MIND, 1972); RCPsych, 'Memorandum on *Hospital Services for the Mentally Ill*' (HM(71)97) NN (July 1972) 3-4 4

³⁸ John Howells, 'The establishment of the Royal College of Psychiatrists' 117-134. In: *150 years* ed. Berrios and Freeman, 119

³⁹ M David Enoch, John Howells, *The Organisation of Psychogeriatrics* (Ipswich: SCP, 1971)

influenced⁴⁰ the development of the DHSS memorandum *Services for Mental Illness Related to Old Age*,⁴¹ a blueprint for future development. Its protagonists often referred to this blueprint almost affectionately by its designation 'HM (72)71'.⁴² As promised, it followed *Hospital Services for the Mentally Ill*.⁴³ Like that document, a draft of HM (72)71 had initially been prefixed with 'Hospital Services'⁴⁴ but the new psychogeriatricians far-sightedly widened the focus to include the community.

HM (72)71 identified three groups of older patients: those with functional illness who were to be treated alongside younger patients in the DGH; those with dementia, to be managed either by psychiatrists or geriatricians, depending on their physical health needs; and long-stay patients who had grown old in hospital.⁴⁵ These categories were relevant clinically and organisationally. Some categories were imprecise, e.g. people with 'significant' physical disease, or on the boundary between 'mild' and 'severe' dementia,⁴⁶ risking disputes concerning responsibility for care.⁴⁷

Long-stay patients who had grown old in hospital were a clinically challenging group. Little attention was usually paid to them. The RCPsych, in a memorandum to the DHSS, estimated that: 'In an average mental hospital a long-stay patient is likely to see a doctor for only 10 minutes or so every three months', hardly enough to facilitate rehabilitation.⁴⁸ Some of the 'difficult' social behaviours which had to be overcome to enable discharge included: spitting in ash trays, blowing noses on ties, eating lighted cigarettes, wearing

⁴⁰ Arie, interview by author (2004)

⁴¹ DHSS, HM (72)71

⁴² Arie, interview by author (2004)

⁴³ DHSS, *Hospital Services*, 1

⁴⁴ BGS/RCPsych, 'Joint report of the on matters relating to the care of psycho-geriatric patients' *NN* (Aug. 1973) 2-3 2

⁴⁵ DHSS, HM (72)71, 1

⁴⁶ *Ibid.* 4-6

⁴⁷ NHS, *Annual Report HAS*, 30

⁴⁸ RCPsych, 'Memorandum on psychiatric manpower as it affects the psychiatric services: to be presented to the central Manpower Committee' (1974) C21/74, EC8/74, MSC6/74, 1 (RCPsychA, Council)

bibs for meals and eating minced food using spoons. Although psychogeriatricians acknowledged a moral and ethical obligation to rehabilitate older long-stay patients, this risked becoming ‘impossibly burdensome’⁴⁹ in terms of their numbers. There was significant friction over this between psychogeriatricians and general psychiatrists: ‘the general psychiatrists were dead keen to get us to take their old schizophrenics’ recollected Pitt.⁵⁰ Some psychogeriatricians, like McDonald, undertook rehabilitation roles. In 1975 he reported on a small cohort of patients: the oldest was 89 and the longest duration of stay was 52 years. None of those discharged opted to return to hospital. McDonald argued passionately for psychogeriatric involvement:

If we, the interested psychogeriatricians, turn our backs ... they will be condemned to live out their lives in our mental hospitals for no better reason than that they have already spent many years incarcerated therein.⁵¹

He was right, but more and better resourced psychogeriatric teams were needed for this to become standard practice.

Bed estimates in HM (72)71 were calculated from a series of hospital censuses.⁵² For community services for severe dementia, 2.5 to three beds plus two to three day places per 1000 over 65s were proposed.⁵³ The trend of stating minimum standards for service provision was not followed, aiming to avoid health authorities interpreting ‘minimum’ as ‘adequate’ or ‘maximum’⁵⁴ and doing no more once that was achieved, although this did not prevent them interpreting it as such. Previously, official reports did not propose services and

⁴⁹ GPOA, minutes, 30.1.1975, 5.e. (RCPsychA)

⁵⁰ Pitt, interview by author (2006)

⁵¹ Carrick McDonald, ‘Responsibility for the graduate population’, attached to GPOA agenda, 24.4.1975, 4 (PJ)

⁵² RJ Eason, JA Grimes, ‘In-patient care of the mentally ill: a statistical study of future provision’ *Health Trends* (1976) 8: 13-18

⁵³ DHSS, HM (72)71, 10

⁵⁴ Pitt to Morris Markowe, (Registrar, RCPsych), letter, 16.7.1974 (PJ)

service levels because data were considered inadequate.⁵⁵ Now, best estimates, based on experience and epidemiological data, guided service planning.

Staffing levels

Based on recent experience, HM (72)71 recommended appointing a psychiatrist in each health authority catchment area with 'special responsibility' for older people.⁵⁶ In 1974, the DHSS acknowledged that:

Where the psychiatric care of the elderly is diffused among the several psychiatrists serving a district, old people are almost inevitably neglected among the competing demands of acute work with younger people.⁵⁷

The DHSS reasserted in 1975: 'in some districts a psychiatrist with a special responsibility for the elderly has been appointed and there may be advantages in this arrangement.'⁵⁸ In 1976 discussions between the DHSS and RCPsych concluded that 'at least one consultant in each district should ... [act] as a focal point for advice and for developing the district's psychiatric services for the elderly'.⁵⁹ Appearing to ignore these recommendations, in 1977, the College and the DHSS proposed a national increase in the number of consultants in general psychiatry without a proportional increase for psychogeriatrics,⁶⁰ a situation only remedied under pressure from the GPOA.⁶¹ In 1978, DHSS proposals for medical manpower recommended five consultants in 'adult' psychiatry and one in child psychiatry for a district of 200,000 people.⁶² This was ambiguous: it may have included some clinical sessions for older people, but did not mention psychogeriatricians. These examples of contradictions and omissions in DHSS/RCPsych proposals and actions, reinforced the need to

⁵⁵ e.g. Phillips Report, 83; Brothwood, 'Organisation' 99

⁵⁶ DHSS, HM (72)71, 6

⁵⁷ DHSS, *Third Report of the Joint Working Party on the Organisation of Medical Work in Hospitals* (Third Cogwheel Report) (London: HMSO, 1974) 13

⁵⁸ DHSS, *Better Services*, 31

⁵⁹ DHSS/RCPsych meeting, 23.6.1976, 'Psychiatric medical manpower' 7 (TNA, MH 150/812)

⁶⁰ RCPsych, 'Providing a district service for adult psychiatry, its special interests and related specialities - medical manpower priorities' (Sept. 1977) EFCC41/77, MSC9/77 (PJ)

⁶¹ Arie to Thomas Bewley, letter, 27.10.1977 (PJ)

⁶² DHSS, *Medical Manpower – the next 20 years* (London: HMSO, 1978) 22

ensure that psychogeriatrics was routinely and explicitly considered in official plans.

Other staffing levels remained undefined. Ward staffing levels were hard to determine since the patients' illnesses and the ward's objectives (acute intervention, rehabilitation or long-stay) meant that demands on staff varied. However, for acute geriatric wards the BGS recommended one nurse for 1.25 patients, and one to 1.5 on geriatric 'continuing care' wards, although the DHSS suggested a lower ratio of one to 1.9.⁶³ For general psychiatric wards one nurse for three patients was recommended in 1972.⁶⁴ In 1978, the RCPsych Council endorsed the GPOA's request for nursing levels close to those on geriatric wards, on a sliding scale between one to 1.2 and one to two depending upon patients' needs and ward objectives.⁶⁵ However, it was unclear to what level of staffing the DHSS was committed, especially where older patients suffered from physical plus behavioural difficulties. The DHSS made generic statements, such as 'there was a minimum standard for mental hospitals, which included elderly patients',⁶⁶ implying that the total number of nurses in the hospital would take into account variation in need between different wards. Precisely how already overstretched staff were to be distributed within hospitals was not stipulated. However, older people seemed unlikely to receive a share determined by their needs when younger people were broadly prioritised for active, staff-intensive, rehabilitative interventions.

At the time, the flexible structure of HM (72)71 appeared rational. Arie regarded it as a 'sensible and workable document, even if it does not clear up all uncertainties or dispel all grounds for misgiving'.⁶⁷ Other interested psychiatrists criticised it for perpetuating 'artificial divisions that have always

⁶³ GPOA, 'Memorandum on nurse staffing needs for the hospital service for the elderly mentally ill' *Psychiatric Bulletin* (1978) 2: 4-5 4; DHSS, 'Minimum standards in geriatric hospitals and departments', letter to RHBs, 19.3.1972, DS95/72 (TA)

⁶⁴ DHSS, 'Minimum standards in hospitals for the mentally ill', letter to RHBs, 22.3.1972, DS86/72 (TA)

⁶⁵ GPOA, 'Nurse staffing'

⁶⁶ GPOA/DHSS, meeting, 21.6.1974, 3 (TNA, MH 150/812)

⁶⁷ Tom Arie, 'Psychogeriatrics' *Age Ageing* (1973) 2: 195-197 195

bedevilled management of elderly psychiatric patients⁶⁸ and not attempting to enforce the provision of services, seeing little likelihood of implementation otherwise.⁶⁹ Complementing HM (72)71, which gave official and specific direction for psychogeriatric services, the GPOA signified the existence of a critical mass of doctors willing to work in them. These were important achievements which might encourage future developments.

Following HM (72)71

Consistent government support for steady service development was not forthcoming. HM (72)71, however, gave the campaigners a basis for persisting with negotiations, centrally and locally. MIND and Age Concern, eager for rapid improvements, were concerned about the slow pace of implementation. A survey they carried out in 1973 found, for example, inadequate assessment facilities,⁷⁰ 'wards of nearly 50 deteriorated and incontinent patients in the care of four nurses',⁷¹ and visitors being discouraged.⁷² As a result, MIND addressed 14 questions to the DHSS. The DHSS confirmed that no timetable had been set for transferring older people from psychiatric hospitals,⁷³ an obstacle to longer term planning. Most other questions remained unanswered, or responses were vague, indicating little commitment.⁷⁴ DHSS intentions for psychogeriatric services remained unclear.⁷⁵

In 1972, a DHSS/RCPsych conference considered older people's needs 'peripheral to the main business'.⁷⁶ In 1973, discussion of psychogeriatrics at a DHSS conference was postponed to a DHSS and BGS conference later that

⁶⁸ Anthony Isaacs, 'Geriatric psychiatry' *Psychiatric Quarterly* (1974) 48: 513-519 517

⁶⁹ Page 221; *Ibid.* 518

⁷⁰ MIND, *Psychogeriatric Services – the questions answered* (London: MIND, 1973) 4

⁷¹ *Ibid.* 5

⁷² *Ibid.* 7

⁷³ *Ibid.* 7

⁷⁴ *Ibid.* 2-10

⁷⁵ MIND, *Questions answered*, 11

⁷⁶ Robert Cawley, 'Planning for the future' *NN* (May 1973) 1-5 4

year.⁷⁷ However, psychiatry was hardly mentioned there despite the question being raised, probably by Arie as the only psychogeriatrician attending, whether psychogeriatrics had been omitted from the programme 'owing to despair at the sheer size of the problem'.⁷⁸ George Godber chaired the conference. He was aware of the issues.⁷⁹ It is unclear why they were not addressed.

The GPOA asked whether the DHSS was 'prepared to condone the inadequacy of services' and requested a meeting with them.⁸⁰ An informal DHSS/GPOA meeting took place in June 1974.⁸¹ The DHSS listened, but offered little commitment. The minutes concluded:

The Department thanked the Group for joining in the interesting discussion. They would welcome further proposals from the College on the holding of a joint Conference on the psychiatric services for old people after the publication of the White Paper.⁸²

Again, an official conference was postponed, this time until after the publication of *Better Services for the Mentally Ill* in 1975, which was mainly concerned with younger people.⁸³ Services for younger people were also slow to improve, but the sequence of older being considered after younger people was repeated. In its evidence to the Royal Commission on the NHS in 1976, the RCPsych emphasised that, for mental health generally, the NHS 'does not meet the needs of the community', noting 'severe deficiencies' in services for mentally handicapped and older people.⁸⁴ The GPOA contributed to the RCPsych's evidence; issues included the need to train staff and support carers;

⁷⁷ DHSS, *Providing a Comprehensive District Psychiatric Service for the Adult Mentally Ill* (HMSO: London, 1974) 12

⁷⁸ DHSS, 'The care of the elderly: proceedings of a conference organised jointly by the DHSS and the BGS', 23.11.1973, 9 (BGSA)

⁷⁹ Fry, 'Keppel Club' 1597

⁸⁰ Pitt to Morris Markowe (Registrar, RCPsych), letter, 17.5.1974 (PJ)

⁸¹ GPOA, minutes, 13.6.1974, 2.b. (RCPsychA)

⁸² GPOA/DHSS, meeting, 21.6.1974, 3 (TNA, MH 150/812)

⁸³ DHSS, *Better Services*

⁸⁴ RCPsych, 'Memorandum of evidence' 1, 4-5; Anon. 'NHS mental health care is criticised' *Times*, 24.2.1977, 3

the practical realities of meeting health and social care needs; the need for specialised services; and achieving objectives already proposed by the DHSS.⁸⁵

In 1976, the DHSS met the director of the HAS, Dr Eluned Woodford-Williams, a geriatrician. The meeting recommended that geriatricians should accept all patients over age 75 except 'severely disturbed patients and those suffering from functional mental illness'.⁸⁶ In a letter concerning service planning in East London, dated the same day, the DHSS advised that geriatricians should take responsibility for psychiatric patients over 75 only if they also had 'significant physical illness or disease'.⁸⁷ Insufficient background information is available to account for the different views, but different proposals indicated unclear lines of accountability and ambiguities concerning creating and providing services.

Ambiguous DHSS guidance, combined with providing for younger before older people,⁸⁸ psychogeriatrics being marginalised in meetings about geriatric medicine and lack of interest in older people among influential general psychiatrists in higher tiers of the RCPsych, ensured, intentionally or otherwise, that psychogeriatric services lagged behind. Change required consistent leadership and determined advocacy to dispel negative myths and stereotypes of older people and drive forward effective clinical practice and service development based on existing and emerging evidence.

Obtaining and interpreting data

DHSS data

In order to plan and evaluate services, adequate data were required. However, before formal recognition of psychogeriatrics as a specialty, the DHSS

⁸⁵ GPOA/Pitt, 'Royal Commission on the Health Service' 12.10.1976 (PJ)

⁸⁶ DHSS and director of HAS, meeting, 12.1.1976, 3 (TNA, MH 150/645)

⁸⁷ P Greenfield (Senior Medical Officer, DHSS) to F Clifford (Service Planning, Tower Hamlets) letter, 12.1.1976 (TNA, MH 150/645)

⁸⁸ e.g. Cawley, 'Planning for the future' 4

collected little specific relevant information. Data often had to be extracted or estimated and were difficult to interpret.⁸⁹

Several examples illustrate this. In official reports, potentially useful data were at times subsumed under the title, 'For the elderly (including the elderly mentally infirm)',⁹⁰ giving imprecise indications of requirements and provision for psychogeriatric disorders. The census of psychiatric day hospital usage was also difficult to interpret. It included people over 65, but recorded attendances only on the last full working day of the year between Christmas and New Year;⁹¹ if family and friends were offering additional support during the festive season this risked indicating under-utilisation of day places, implying that provision was adequate. In another example, routine data did not indicate whether psychogeriatric or general adult psychiatric teams provided treatment for older people, or whether outcomes differed. In contrast, separate data were collected by the DHSS for older people treated within geriatric medicine or by other hospital specialties.⁹² It would have been reasonable to expect similar treatment of mental health.

Non-uniform official statistics were difficult to compare. Old age data from the DHSS in 1976 related to people over 65 years in England,⁹³ but the Audit Commission in 1986 used data for over 75s in England and Wales.⁹⁴ The DHSS source mainly linked old age mental illness to physical health and frailty under, 'services used mainly by the elderly',⁹⁵ which did not correspond with psychogeriatric service leadership or lines of accountability. The Audit Commission divided people with incapacities into four 'client groups': elderly,

⁸⁹ David Jolley, Tom Arie, 'Organisation of psychogeriatric services' *BJPsych* (1978) 132: 1-11 7

⁹⁰ MoH, *Health and Welfare* (Revision to 1975/76) 412

⁹¹ DHSS, *The Facilities and Services of Psychiatric Hospitals in England and Wales 1972* (London: HMSO, 1974) 50

⁹² DHSS, *Hospital In-patient Enquiry Main Tables 1978* (London: HMSO, 1978) 222-223

⁹³ DHSS, *Priorities*

⁹⁴ Audit Commission, *Making a Reality*

⁹⁵ DHSS, *Priorities*, 38-44, 64-61

mentally ill, mentally handicapped and physically handicapped,⁹⁶ with vague comments on psychogeriatric services which were not confined to any one section. Falling precariously across other priority areas, without explicit recommendations, it was likely that responsibility at government level for providing psychogeriatric services would remain unclear and objectives would not be achieved.

Management, not clinicians, determined the data to be collected. In the 1980s, new NHS mandatory 'performance indicators' which measured quantity of work, rather less meaningful than clinical effectiveness, were at times inaccurate and misleading⁹⁷ and did not capture activity such as routine home assessments by psychogeriatricians, hence failing to identify recognised age-appropriate good practice which required resourcing.⁹⁸ DHSS data ignored the unusual characteristics of specialist psychogeriatrics,⁹⁹ a secondary health care service spanning hospital and community.

Lack of specific psychogeriatric service data was acknowledged by Roland Moyle, Minister of State for Health in 1978, but without suggestions to remedy the deficit.¹⁰⁰ In 1981 the DHSS acknowledged the need to collect specific data,¹⁰¹ but it reached no agreement about this with the RCPsych.¹⁰² In 1988, the DHSS protocol for collecting data on 'sub-specialties' was: 'they are ignored and the episode is coded under the appropriate main specialty. We have no plans to change this'.¹⁰³ Difficulties obtaining and interpreting official

⁹⁶ Audit Commission, *Making a Reality*, 7

⁹⁷ Gyles Glover, Richard Farmer, David Preston, 'Indicators of mental hospital bed use' *Health Trends* (1990) 22: 111-115

⁹⁸ Arie to P Mason (DHSS), letter, 24.9.1987 (RCP, MS4814); John Wattis, 'Measuring performance or balancing the budget' *BMJ* (1987) 295: 1000

⁹⁹ Karen Robinson to Rachel Jenkins (PMO, DHSS) memo, 28.11.1988 (TNA, MH 154/935)

¹⁰⁰ Roland Moyle, 'Elderly mentally infirm persons' HC Deb 14.11.1978 *Hansard* Vol. 958 c201W (Written Answers)
http://hansard.millbanksystems.com/written_answers/1978/nov/14/elderly-mentally-infirm-persons#S5CV0958P0_19781114_CWA_425 accessed 23.9.2012

¹⁰¹ DHSS/SPOA, meeting, 11.6.1981, 3 (TNA, MH 154/1328)

¹⁰² DHSS/RCPsych, meeting, 24.7.1981, 2 (TNA, MH 154/935)

¹⁰³ Karen Robinson to Rachel Jenkins (PMO, DHSS), memo, 28.11.1988 (TNA, MH 154/935)

data risked hindering service planning, and historical analysis. The need to obtain specific and relevant data was a spur to the campaign (1987-9) for official recognition of the specialty.¹⁰⁴

Data about the psychiatric hospitals

Calculations of psychiatric hospital bed numbers in England have to be drawn from various sources, are difficult to compare and must be regarded as approximations. In particular, bed occupancy might not reflect workload: one bed could accommodate one long-stay patient in a year, or a succession of people requiring intensive treatment and rehabilitation. Despite limitations in the data, trends were apparent. Beds continued to decline in England and Wales from about 136,000 in 1960¹⁰⁵ to 94,000 in 1973¹⁰⁶ and to 80,000 in 1978,¹⁰⁷ attributed mainly to shorter admissions for younger patients. Relative to their numbers in the population (in 1975: age 65-74, 9%; over 75, 5%)¹⁰⁸ older people occupied these beds disproportionately: 44,000 (47%) in 1973 by over 65s¹⁰⁹ and 20,000 (25%) in 1978 by over 75s.¹¹⁰ Psychiatric hospitals were becoming elderly care institutions, as Lewis had predicted three decades earlier.¹¹¹ Whitehead wrote in 1972: 'mental hospitals are becoming understaffed, neglected dumps for the elderly'.¹¹² He reiterated this in the *Lancet* eleven years later.¹¹³ Bed occupancy trends were expected to continue, with projections that two-thirds would be occupied by people over 65 by 1981.¹¹⁴

¹⁰⁴ Pages 317-321

¹⁰⁵ *Registrar General's Statistical Review*, 13

¹⁰⁶ DHSS, *The Facilities and Services of Psychiatric Hospitals in England and Wales 1973* (London: HMSO, 1976) 54-55

¹⁰⁷ DHSS, *Happier Old Age*, 36

¹⁰⁸ OHE, 'UK resident population'

¹⁰⁹ DHSS, *Facilities and Services 1973*, 54-55

¹¹⁰ DHSS, *Happier Old Age*, 36

¹¹¹ Lewis, 'Ageing and senility' 169

¹¹² Whitehead, 'Now tell us' 5

¹¹³ Tony Whitehead, 'Closing large mental hospitals' *Lancet* (1983) ii: 1139-1140

¹¹⁴ Felix Post, Tom Arie, 'Training: consultant manpower' Report for RCPsych Manpower Committee, 24.10.1974 (PJ)

Similar trends were apparent in Scotland,¹¹⁵ in state mental hospitals in the USA¹¹⁶ and other developed countries.¹¹⁷

The gradual decline in psychiatric hospital bed occupancy should have provided opportunities to improve morale and nursing quality by increasing staff-patient ratios.¹¹⁸ In reality, as younger people were discharged, little changed in terms of in-patient or community resources for older people¹¹⁹ who continued to be admitted to psychiatric hospitals designated for closure. The DHSS's view persisted: large numbers of older people in psychiatric hospitals were detrimental to patient care, staff morale and nurse recruitment.¹²⁰ Alternative likely influences on low morale, such as neglect of the work environment and uncertainty of the future of the hospitals and hence of local employment, were sometimes mentioned,¹²¹ but were less prominent than arguments blaming older people. Older people were an easy scapegoat, despite evidence that enthusiastic psychogeriatric leadership could boost team morale.¹²²

Arie had a specific interest in staff morale.¹²³ He commented that nurses on long-stay wards still regarded themselves as working in a 'dumping ground' where 'failures' accumulated; the very different goals of 'cure' and 'care and maximisation of function' were still not appreciated.¹²⁴ However, nurse morale was a complex issue. Arie, on the basis of observations at Goodmayes, noted that doctors made incorrect assumptions about the work or the patients that they

¹¹⁵ SHHD, *Services for the Elderly*, 16

¹¹⁶ Ballenger, *Self, Senility*, 37-39

¹¹⁷ WHO, *Psychogeriatrics*, 18

¹¹⁸ MoH and Central Health Services Council, *Psychiatric Nursing*, 175

¹¹⁹ GPOA/Pitt, 'Royal Commission' (PJ)

¹²⁰ Brothwood, 'Organisation' 110; DHSS, *Organisational and Management Problems of Mental Illness Hospitals: report of a working group* (Nodder Report) (London; DHSS, 1980) 60

¹²¹ DHSS/RCPsych, meeting, 8.9.1972 (RCPsychA, Council)

¹²² Arie, 'First year' 1180

¹²³ Arie, 'Morale'

¹²⁴ Arie and Isaacs, 'Development of psychiatric services' 255

thought nurses would like: whether the patients were pleasant or gloomy affected nurses' work satisfaction more than whether the care they provided was heavy or messy.¹²⁵

To some degree, the need for institutional care reflected age-related degenerative disorders and the needs of ageing long-stay patients with illnesses dating back many years. Other factors affecting bed use were less justifiable and reinforced the view that younger people were prioritised for modern community and rehabilitation services. This was probably partly related to stereotypical views of the likelihood of recovery in older people and of younger people's perceived economic value. The use of assumed future economic potential of individuals as a basis for DHSS prioritisation helps to explain difficulties in resourcing services for older and disabled people.¹²⁶ Similarly, funding for hospices caring for dying people was largely provided by charities rather than the government.¹²⁷ Other explanations for the high numbers of older in-patients include clinically unnecessary admissions; patients remaining in hospital when they no longer required treatment and could have been supported better elsewhere; limited provision of community residential and domiciliary services; unsupported families unable to cope with caring for older people. One study by the Newcastle team indicated that behavioural difficulties caused significant distress in over half the families caring for an older person with mental illness.¹²⁸ Potentially curable conditions such as depression remaining undiagnosed probably also contributed to bed occupancy. Whitehead explained this tragedy in the *Guardian* in 1974:

Old people may spend their last years in dreadful misery because severe depression has been wrongly diagnosed as senile decay ... If you are anxious and depressed, and more and more people start treating you as if

¹²⁵ Tom Arie, In: 'Discussion' 115. In: *Brain Failure in Old Age: proceedings of a conference held in December 1975 in Jersey, Channel Islands.* ed. W Ferguson Anderson, JR Carlton-Ashton. *Age Ageing* (1977) supplement

¹²⁶ Millar, 'Disability' 170

¹²⁷ I Higginson, 'Palliative and terminal care' 183-260. In: *Health Care Needs Assessment: the epidemiologically based needs assessment reviews* ed. Andrew Stevens, James Raftery (Oxford: Radcliffe, 1997) 186

¹²⁸ Klaus Bergmann *et al.* 'Management of the demented elderly patient in the community' *BJPsych* (1978) 132: 441-449 447-448

you were a difficult child, and you are finally incarcerated in a ward full of other elderly people who are being treated in the same way, it is likely that in time you will give up and take on the role of not just a child, but a baby.¹²⁹

Data on mental illness

Accurate data on old age mental illnesses, especially dementia, were elusive, risking prevalence being underestimated and further hindering planning. These difficulties were acknowledged in parliament.¹³⁰ There were various reasons for them. Dementia might be under-diagnosed in primary care, due to patients and GPs normalising symptoms as part of ageing. It was often missed in hospital statistics collected for patients admitted under the care of general medical or geriatric physicians.¹³¹ It was often not recorded on death certificates. In 1970, official mortality tables specified neither ‘senile dementia’ nor Alzheimer’s disease.¹³² In 1979, Alzheimer’s disease was recorded as a cause of death on 17 certificates nationally and ‘senile dementia’ on 2,416.¹³³ The tiny numbers of the former were probably related to perpetuation of the outdated notion that Alzheimer’s only affected younger people. This was in line with the WHO’s International Classification of Diseases (ICD) in 1967 and 1977. These were limited by being lists of diagnoses without further clarification, giving no reasons why pre-senile and senile dementia were categorised separately,¹³⁴ despite being pathologically the same condition.¹³⁵ The American classification system in 1968 also separated pre-senile and senile dementia, despite stating that ‘diagnosis should be based

¹²⁹ Tony (Anthony) Whitehead, Cited in: Anon. ‘Aged “could be spared misery”’ *Guardian*, 7.10.1974, 6

¹³⁰ Michael Meacher, ‘Elderly mentally infirm persons’ HC Deb 29.6.1971 *Hansard* Vol. 820 cc80-1W http://hansard.millbanksystems.com/written_answers/1971/jun/29/elderly-mentally-infirm-persons#S5CV0820P0_19710629_CWA_116 accessed 23.9.2012

¹³¹ Jolley to Pitt, letter, 8.4.1977 (PJ)

¹³² DHSS, *On the State of the Public Health: the annual report of the chief medical officer of the Department of Health and Social Security for the year 1970* (London: HMSO, 1970) 22-23

¹³³ Liz Kirby, Petra Lehmann, Azeem Majeed, ‘Dementia in people aged 65 years and older: a growing problem?’ *Population Trends* (1998) 92: 23-28 25

¹³⁴ WHO, *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death* (Geneva: WHO, Eighth Revision 1967-69, Ninth Revision 1977-78) 290.0, 290.1

¹³⁵ Corsellis, *Mental Illness and the Ageing Brain*

on the brain disorder present and not on the patient's age at times of onset'.¹³⁶ Other diagnoses, such as depression and schizophrenia, were not categorised by age. A chronological age divide for dementia alone appeared illogical. This was likely to perpetuate misunderstandings and prejudice the planning and provision of services. Despite some improvements, according to Aubrey Lewis in 1972, psychiatric diagnostic classification 'remained a battlefield'.¹³⁷

For the population aged over 65, of whom around 8-10% had these disorders,¹³⁸ the official mortality figures are unrealistically low. Lack of recording could be accounted for by older people with dementia dying of acute physical illnesses, and, although dementia probably contributed to their demise, doctors certifying death may not have been aware of it. Even if they were aware, there were ethical considerations: adding a stigmatising diagnosis to a death certificate could be distressing to the family if they were previously ignorant of it. In addition, 'old age' was a permitted category on death certificates, and might subsume dementia. Accuracy of death certification became particularly problematic after 1976 when the distribution of NHS funds was based on mortality statistics as a proxy for morbidity and health need.¹³⁹ Death certification indicating high cardiac mortality, for example, reinforced the need for cardiology services,¹⁴⁰ whereas mortality data for chronic mental illness was concealed by the requirements of death certification, contributing to underestimating need.¹⁴¹

¹³⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, DSM-II* (Washington DC: APA, 1968) 24

¹³⁷ Aubrey Lewis, 'Introduction' 1-5. In: *Psychiatric Diagnosis in New York and London: a comparative study of mental hospital admissions* ed. JE Cooper *et al* (London: OUP, 1972) 1

¹³⁸ Kay, 'Old age mental disorders: prevalence' 150

¹³⁹ DHSS, *Sharing Resources for Health in England: report of the Resource Allocation Working Party* (London: HMSO, 1976) 16; Roy Carr-Hill, 'Revising the RAWP formula: indexing deprivation and modelling demand' (CHE, 1988) 1
<http://www.york.ac.uk/che/publications/in-house/archive/1980s/> accessed 19.11.2012

¹⁴⁰ Michael Joy, Isabel Huggett, 'Cardiology in a district hospital' *BMJ* (1982) 285: 790-792 790

¹⁴¹ DAK Black, JD Pole, 'Priorities in biomedical research: indices of burden' *BJPSM* (1975) 29: 222-227

Data related to community services

In the absence of DHSS data, MIND,¹⁴² Kay and Roth, the GPOA as a body and individual psychogeriatricians undertook their own studies and participated in surveys.¹⁴³ Starting in 1979, psychogeriatrician John Wattis undertook several surveys of psychogeriatric services. Another unrecognised specialty, substance misuse, similarly analysed its services.¹⁴⁴

In 1974 a survey of GPOA members about their resources and working practices was undertaken by the Health Care Evaluation Research Team at the University of Southampton. They sought precise numbers of beds, day places and other resources, which probably minimised biased reporting, both over- or under- estimates, but could not exclude it. Significantly, the study found that no locality surveyed had all the facilities the DHSS believed to constitute a comprehensive service.¹⁴⁵ This made it impossible to make meaningful statements as to whether or not proposals for services were adequate.

The DHSS in 1976 aimed to increase provision of 'services used mainly by the elderly' by 3.2% a year.¹⁴⁶ In 1986, data from the Audit Commission (Table 3) suggest that these aims were only partly achieved.¹⁴⁷ For example, home helps and meals on wheels, which might have enabled older people to remain at home, only increased in line with demographic changes. Starting from a position of unacceptably low provision which did not meet needs,¹⁴⁸ services remained insufficient.

¹⁴² MIND, *Now Tell Us*, 3-4; MIND, *Questions answered*

¹⁴³ e.g. David Jolley, 'Hospital inpatient provision for patients with dementia' *BMJ* (1977) i: 1335-1336; Anon. 'University Departments' *NN* (July 1974) 7-9 8; GPOA, Brice Pitt and Gordon Langley, letters, Feb.1978 (PJ)

¹⁴⁴ Manpower Committee, minutes, 13.6.1985, MC12/85, 3/85.ii. (RCPsychA)

¹⁴⁵ A Kushlick, R Blunden, 'Project to look at how psychogeriatricians organise their work to inform Group and DHSS on adequacy or otherwise for provision of psychiatric facilities for old people' (1974) (PJ)

¹⁴⁶ DHSS, *Priorities*, 3

¹⁴⁷ Audit Commission, *Making a Reality*, 19

¹⁴⁸ Home Office, 'Expenditure on the National Health Service' Cabinet Report, 2.3.1978, 2 (TNA, CAB 129/200/3); RCPsych, 'Memorandum of evidence' 4-5

Table 3. Audit Commission 1986: ‘Balance of care for elderly people’ (England and Wales)

	Number of units (n), and rate per 1000 over 75		
	1974 n (per 1000)	1979 n (per 1000)	1984 n (per 1000)
Local authority day centre places	13,800 (5.6)	29,100 (10.5)	34,000 (10.9)
Day hospital ^a attendances per day	4,100 (1.7)	5,000 (1.8)	7,000 (2.2)
Total occupied beds in homes and geriatric hospitals ^b	209,500 (84.2)	229,800 (82.8)	269,300 ^c (85.1)
Home helps (whole time equivalent)	45,000 (18.3)	49,600 (17.9)	56,700 (17.9)
Meals on wheels (000s per year)	35,200 (14.3)	43,300 (15.6)	45,000 (14.2)

a. Unclear if geriatric and/or psychiatric.

b. Excluding psychiatric hospitals.

c. Increase mainly within the private sector.

Source: Audit Commission, *Making a Reality*, 19

For some figures in table 3, the method of calculation was problematic, making meaningful interpretation difficult. For example, it is unclear how day centre ‘places’ compared with day hospital ‘attendances per day’. The inconsistent units of data suggest an agglomeration of information from diverse sources rather than coordinated and targeted data collection. It is also unclear why long-stay psychiatric hospital beds occupied by older people were excluded from the residential calculations. The total number of ‘resident patients’ in psychiatric hospitals was declining (England, 1981: total 73,000 of which 23,000 over 75¹⁴⁹); it is unclear if including psychiatric hospitals would have changed the overall trend for institutional beds. Any stated figures on this matter need to be treated cautiously as there are suggestions that officially calculated figures on ‘psychogeriatric’ (without further definition) bed use might be inaccurate. For example, the DHSS reported an unlikely 10-fold difference between these beds in different NHS Regions in 1986: North West Thames was said to have 158, while Trent had 1,453.¹⁵⁰

¹⁴⁹ DHSS, *In-Patient Statistics from the Mental Health Enquiry for England. 1981* (London: HMSO, 1984) 54

¹⁵⁰ DHSS, *Hospital Statistics - form SH3 'National and Regional Summaries for 1986'* Prepared by Government Statistical Services (1987) 52, 33; Arie, discussion, Nov. 2012

Recruitment and training

Stigma by association

‘Stigma by association’ means attaching negative characteristics of a disadvantaged group to those supporting them.¹⁵¹ The popular image of the ‘mad psychiatrist’ embodies this in public and professional circles.¹⁵²

Some psychiatrists, incredulous that their colleagues might want to work with older people, were concerned about acquiring stigma by treating them.¹⁵³ In 1985, RCPsych president, Thomas Bewley, commented:

it was quite difficult to discover what percentage of a psychiatrist’s sessions were spent on caring for old people, part of the problem being that the general psychiatrist might have fears about being labelled as a psychogeriatrician.¹⁵⁴

Psychogeriatricians themselves ironically created negative images, probably reflecting their interpretation of how others perceived their professional roles. Jolley commented:

Tom Arie has likened our role to that of a longstop on the cricket field, which I frequently perverted to the man who follows along behind the Royal parade with a bucket and shovel.¹⁵⁵

Other staff received derogatory labels. At the Bethlem-Maudsley Geriatric Unit, nurses were known as ‘shit shovellers’ by their colleagues.¹⁵⁶

¹⁵¹ Simon Olshansky, ‘Stigma: its meaning and some of its problems for vocational rehabilitation agencies’ *Rehabilitation Literature* (1965) 26: 71-74

¹⁵² G Walter, ‘The stereotype of the mad psychiatrist’ *Australian and New Zealand Journal of Psychiatry* (1989) 23: 547-554

¹⁵³ Manpower Committee, minutes, 9.10.1980, 22/80.v. ‘The psychiatry of old age - a specialty?’ (RCPsychA)

¹⁵⁴ Planning meeting for RCP/RCPsych joint working party, 25.9.1985 (RCPA, MS4811)

¹⁵⁵ David Jolley, ‘Editorial’ *SPOA Newsletter* (1985) 7: 14; *SPOA Newsletters* in the 1980s were all edited by David Jolley and editorial comments not otherwise attributed were made by him (e-mail, David Jolley, 21.5.2013)

¹⁵⁶ Jim Birley, ‘Psychogeriatrics: the smell of success or the odour of chronicity?’ *IJGP* (1987) 2: 131-134 131

Derogatory labels could be adopted with pride, indicating a shared identity in the face of adversity, a sense of humour in coping with it, and becoming a spur to action. Psychiatrist Jim Birley likened ‘the odour of chronicity’, another negative image, to ‘the whiff of gunpowder in the nostrils of seasoned and well-trained troops’.¹⁵⁷

Disparaging views implied that staff outside the field regarded the work distastefully. Robin Jacoby, subsequently professor of psychogeriatrics, described his own negative sentiments before he entered the field.¹⁵⁸ Initial distaste had to be tackled or older people’s services would have difficulty competing for good staff against more glamorous specialties.

Against the background of ageism, stigma and distaste for the work, the SPOA welcomed the RCPsych Council’s recommendation in 1980 that all psychiatric trainees should ‘spend a significant amount of their time’ working in specialist psychogeriatric units. The SPOA proposed that ‘significant’ should be interpreted as ‘a minimum of six months at both registrar and senior registrar level’ although it is unclear if that was accepted by Council.¹⁵⁹ Ensuring that all trainees experienced the rewards of the specialty, with charismatic clinical leadership and inspiring teaching, could help overcome stereotypical ideas and encourage recruitment.¹⁶⁰

Training consultant psychogeriatricians

Ensuring the appointment of trained, safe and effective consultant psychogeriatricians to treat patients and lead services was a central task of the GPOA/SPOA. ‘Specialist’ training took place at senior registrar (SR) level, the grade preceding consultant appointment. Various ideals for psychogeriatric specialist training were proposed, usually totalling three to four years duration, although the minimum recommended in 1974 was one year full-time in

¹⁵⁷ Birley, ‘Smell of success’ 134

¹⁵⁸ Jacoby, ‘Witness’ 100

¹⁵⁹ Gerald Timbury, ‘Training in the psychiatry of old age’ *Psychiatric Bulletin* (1981) 5: 173

¹⁶⁰ John Wattis, CW Smith, V Binns, ‘Medical students’ attitudes to old people and career preferences: a comparison of two universities’ *Medical Education* (1986) 20: 498-501

psychogeriatrics and three in general psychiatry.¹⁶¹ The precise process for creating training posts was sometimes unclear, as reflected in Arie's comment in 1979: 'this is proving confusing. I would not like to claim that I am 100% sure that I know what is happening – or that I know who does!'¹⁶² Identifying sources to clarify the process has also been difficult.

In 1973, there were insufficient trained SRs to apply for the number of advertised consultant psychogeriatric posts,¹⁶³ a situation which continued into the 1980s.¹⁶⁴ Reasons included a shortage of training posts. In October 1973 the GPOA wrote to the DHSS requesting around six new training posts.¹⁶⁵ Each post would provide a one year psychogeriatric placement. This was probably realistic, since training is supervised by consultants in the field, a 'chicken and egg' situation for a new specialty. The GPOA's letter probably initiated an invitation for their representatives to attend the College Manpower Committee. This committee expressed 'some opposition to the sub-specialty of Psychogeriatrics' but nevertheless supported the creation of dedicated SR posts.¹⁶⁶ The DHSS approved them but they remained un-funded.¹⁶⁷ Bewley, at that time College sub-dean, explained that individual psychogeriatricians wishing to provide specialist training would need to negotiate funding locally.¹⁶⁸ Central funding at that time was probably meagre for all psychiatric specialties and resources depended on the Regions' priorities.¹⁶⁹ To guarantee sufficient training posts was far from straightforward.

¹⁶¹ GPOA, minutes, 24.10.1974, 2.c.i. (RCPsychA)

¹⁶² Arie to Peter Jefferys, letter, 19.11.1979 (TA)

¹⁶³ GPOA, minutes, 10.10.1973, 7 (RCPsychA)

¹⁶⁴ SPOA, minutes, 20.9.1984, 32SPOA/84 (RCPsychA)

¹⁶⁵ GPOA, minutes, 10.10.1973, 7 (RCPsychA)

¹⁶⁶ GPOA, minutes, 28.3.1974, 2.g. (RCPsychA)

¹⁶⁷ GPOA, minutes, 26.6.1975, 9 (RCPsychA)

¹⁶⁸ GPOA, minutes, 30.10.1975, 6.h. (RCPsychA)

¹⁶⁹ Letter from Thomas Bewley, 23.8.2012

For SRs, or interested consultants wishing to retrain in psychogeriatrics,¹⁷⁰ in 1975, the British Postgraduate Medical Federation (established to improve and coordinate postgraduate training in the London area¹⁷¹) recognised training secondments in three places: the Bethlem-Maudsley, Goodmayes and Tindal General, Aylesbury, led by Michael White and Roy Simons.¹⁷² Newcastle also offered training;¹⁷³ their regional health authority was ‘hugely supportive’ in funding it.¹⁷⁴ Despite the small number, these were all departments with a first-rate reputation. Jolley commented about his secondments before taking up his consultant post in Manchester: ‘The personal contacts made ... provided the feeling that one was joining an interesting and exciting club ... a great deal is being achieved’.¹⁷⁵

Based on DHSS recommendations for England and Wales¹⁷⁶ to provide one ‘whole time equivalent’ psychiatrist dedicated to older people in each district,¹⁷⁷ there were around 200 psychogeriatric consultant vacancies in 1978.¹⁷⁸ With only six (some sources say seven¹⁷⁹) existing SR training posts nationally,¹⁸⁰ even if all posts were full and all SRs holding them finally opted for full time psychogeriatric careers, there would be a maximum of 28 more consultants four years later. Filling the vacancies seemed unlikely within a reasonable timeframe. Arie described the consequences of this as a ‘political

¹⁷⁰ GPOA, minutes, 30.1.1974, 2.c.; Tony (Anthony) Whitehead, ‘Training in geriatric psychiatry’, GPOA, minutes, 28.3.1974, 2.e. (RCPsychA)

¹⁷¹ George Smart, ‘The state of British medicine – 3: the British Postgraduate Medical Federation’ *Journal of the Royal Society of Medicine (JRSM)* (1978) 71: 167-169 167

¹⁷² Michael (DMD) White, autobiographical note, ‘Witness’ 76-77; Brice Pitt, ‘Group for the psychiatry of old age’ *NN* (May 1975) 21

¹⁷³ GPOA, minutes, 24.10.1974, 2.c.i. (RCPsychA)

¹⁷⁴ Garry Blessed, letter, 7.6.2013

¹⁷⁵ Jolley, ‘Psychiatrist into psychogeriatrician’ 12-13

¹⁷⁶ Anon. ‘Providing a district service for general psychiatry, its special interests and related specialties: medical manpower priorities’ *Psychiatric Bulletin* (Dec. 1977) 1: 5-7 1

¹⁷⁷ SPOA working party, ‘Medical manpower in the psychiatric specialties’ May 1980 (RCPsychA); John Wattis, Tom Arie, ‘Further developments in psychogeriatrics in Britain’ *BMJ* (1984) 289: 778

¹⁷⁸ Arie, cited in: Anon. ‘Meeting’ 515

¹⁷⁹ SPOA working party, ‘Medical manpower in the psychiatric specialties’ May 1980 (RCPsychA)

¹⁸⁰ Manpower Committee, minutes, 16.12.1980, 27/80.d.i. (RCPsychA)

emergency'.¹⁸¹ Sometimes, unrealistic training ideas were put forward by the College, e.g. SRs should be allocated to the most understaffed areas.¹⁸² That was inappropriate: understaffed areas had few, if any, consultants to provide training, reinforcing the impression of lack of understanding of the specialist nature of psychogeriatrics.

A further seven temporary, un-funded, psychogeriatric training posts each approved for three to four years, for which Regional Health Authorities (RHAs) would have to bid, were agreed in 1980.¹⁸³ They might provide an extra 28 trained psychogeriatricians at the end of the four year period,¹⁸⁴ although it could be fewer, since those posts could be filled by future general psychiatrists. These additional posts would be re-designated from general psychiatry.¹⁸⁵ Psychogeriatricians thus had no option but to compete against their colleagues for training resources, which was unlikely to ensure mutually helpful working relationships. General psychiatrists might not want to work with old people but nor did they want their own workforce reduced. The situation might have fuelled their ambivalence towards the new specialty.

In 1984, the additional temporary posts were judged by the College Manpower Committee to have been 'very effective',¹⁸⁶ suggesting interest in them by trainees and a willingness by RHAs to fund them. Arguments about recruitment difficulties for psychogeriatrics¹⁸⁷ appeared less strong. Meanwhile, the RCPsych proposed that, to achieve consultant targets in all specialties, SR numbers should be approximately one-fifth of the total required

¹⁸¹ Arie, cited in: Anon. 'Meeting' 515

¹⁸² JCHPT, minutes, 14.11.1979, 2.b. (RCPsychA)

¹⁸³ Manpower Committee, minutes, 6.7.1979, 24/79.b. 'Report of the meeting with the DHSS' 26.6.1979, iii.; Manpower Committee, 16.12.1980, 27/80.d.i. (RCPsychA)

¹⁸⁴ SPOA, Manpower working party, 22.5.1980; SPOA, minutes, 3.12.1981, Shore to SPOA, letter, 37EC/81 (RCPsychA)

¹⁸⁵ JCHPT, minutes, 24.11.1979, 2.b. (PJ)

¹⁸⁶ Manpower Committee, minutes, 16.2.1984, 5/84.i. (RCPsychA)

¹⁸⁷ Dr Elizabeth Shore to Professor Desmond Pond, letter, 20.2.1980 (RCPsychA, Group into Section)

for the consultant grade.¹⁸⁸ Psychogeriatric training posts were still too few. Eventually, in 1986, the Manpower Committee seemed to recognise some advantages of dedicated psychogeriatric training posts and proposed that general psychiatry might relinquish some of their posts to psychogeriatrics.¹⁸⁹

Appointing the consultants

Some health authorities were enthusiastic about appointing consultant psychogeriatricians. Others did not have clear or realistic conceptions of psychogeriatricians' roles and responsibilities. White commented on the view that:

“Psychogeriatrics” is the non-specialty of our time ... there is no clear model in the minds of those planning it ... they honestly believe that psychogeriatrics is a dead-end job for which no psychiatrist in his right mind applies.¹⁹⁰

In 1977, the Yorkshire Regional Manpower Committee refused to fund consultant and SR posts. It was later discovered that there were neither psychiatrists nor geriatricians on that committee, hence the objectives of the posts were perhaps not understood.¹⁹¹ It was clear that doctors working with older people would be crucial to advise the Regions, as Jolley did when appointed first consultant psychogeriatrician in the North West Region in 1975.¹⁹² His appointment followed the deaths of nine patients transferred from Fairfield Hospital to inadequately heated, furnished and staffed wards at Rossendale Hospital in the winter of 1973/4. The findings of the inquiry were disturbing,¹⁹³ but the Region took action to try to prevent repetition.

¹⁸⁸ Fiona Caldicott, 'The Short Report and its implications' *Psychiatric Bulletin* (1982) 6: 155-157 155

¹⁸⁹ Manpower Committee, minutes, 5.6.1986, 13/86.iv. (RCPsychA)

¹⁹⁰ DMD White, 'What's wrong with psychogeriatrics?' *Psychiatric Bulletin* (1979) 3: 89-90 89

¹⁹¹ GPOA, minutes, 6.10.1977, 77/77.i. (RCPsychA)

¹⁹² Jolley, e-mail, 2010

¹⁹³ North Western RHA, 'Transfer'

Wattis's survey of psychogeriatric services in 1979/80 indicated numbers of consultants.¹⁹⁴ His findings provoked a question in Parliament from Labour MP, Lewis Carter-Jones, as to the number of health districts with a specialist psychogeriatrician. Geoffrey Finsberg, Parliamentary Under Secretary of State

for the DHSS, sought clarification from the RHAs,¹⁹⁵ who confirmed the gaps in provision (Table 4).¹⁹⁶ Overall provision may have been even lower due to the vagueness of the term 'special interest', and only 39 of the 105 identified were full-time consultants.¹⁹⁷

Table 4. Distribution of 'consultant psychiatrists with a special interest in the elderly' in England (based on 1979-80 data)

Region	Number of districts	Number of districts with special interest consultant	% of districts with special interest consultant
Northern	16	6	38
Yorkshire	17	11	65
Trent	17	7	41
East Anglia	7	3	43
N-W Thames	18	5	28
N-E Thames	17	14	82
S-E Thames	16	7	44
S-W Thames	14	13	93
Wessex	10	9	90
Oxford	7	6	86
South West	10	9	90
W Midlands	22	6	27
Merseyside	10	4	40
North West	18	5	28
Total	199	105	53

Source: Finsberg, HC Deb, 29.10.1981

The DHSS acknowledged that identifying the differences between regions might provoke local action:

¹⁹⁴ Wattis, 'National survey'

¹⁹⁵ Geoffrey Finsberg, 'Dementia: Social Services' *Hansard* Written answers 21.10.1981 <http://www.theyworkforyou.com/wrans/?id=1981-10-21.155.11> accessed 11.5.2012

¹⁹⁶ Geoffrey Finsberg, 'Dementia' HC Deb 29.10.1981 *Hansard* Vol. 10 cc456-7W 456W http://hansard.millbanksystems.com/written_answers/1981/oct/29/dementia accessed 11.5.2012

¹⁹⁷ Wattis, 'National survey' 1529

members of regional authorities and other interested people will ask uncomfortable questions in the laggard Regions, which may often be laggards because the regional medical officer has failed to form any plan for getting such a psychiatrist in each district.¹⁹⁸

Despite the ‘naming and shaming’ approach, some laggards remained. Some created posts labelled ‘psychogeriatric’ that were quite tokenistic but enabled some managers to claim to fulfil their commitment to appoint a consultant psychogeriatrician. There were examples of posts advertised as having a ‘special interest in the elderly’ which allocated less than 1.5 days a week to psychogeriatrics,¹⁹⁹ plus a ragbag of other tasks perhaps unwanted by existing psychiatrists, such as assessing young women requesting terminations of pregnancy on psychiatric grounds.²⁰⁰ It would have been difficult to undertake the clinical psychogeriatric responsibilities in the allotted time, let alone develop services. Tokenistic posts were more likely to attract applicants having difficulty securing any consultant appointment rather than those well trained and enthusiastic about developing psychogeriatric services. ‘Ragbag’ jobs reinforced the view that the skills and interests of genuinely aspiring specialist psychogeriatricians were not understood.

Other posts were unsupported, for example, a new consultant leading a department being ‘expected to manage with half an office and a third share in an inferior typist’.²⁰¹ The RCPsych, monitoring new consultant appointments, was concerned that a significantly high proportion of old age jobs, compared with other specialties, were too onerous to be workable.²⁰²

Despite sound ideals of only appointing consultants to adequately resourced posts, in 1978, in order to appoint a second consultant in some districts, Arie

¹⁹⁸ PM Williamson to Miss Doran (DHSS) letter, 13.10.1981 (TNA, MH 154/1328)

¹⁹⁹ Anon. ‘Guidelines on developing psychiatric consultancies with a special interest in the elderly’ (c.1978) 1.2 (PJ)

²⁰⁰ White, ‘What’s wrong’ 89

²⁰¹ Anon. ‘Guidelines’ 1.3 (PJ)

²⁰² Peter Brook, ‘Assessors’ reports on advisory appointments committees’ *Psychiatric Bulletin* (1979) 3: 7-10 9

proposed filling relatively un-resourced posts since resources would not be allocated until someone was in place to fight for them.²⁰³ Inequitable distribution of resources occurred. For example, the admired psychogeriatric service at Redruth, Cornwall which hosted numerous visiting dignitaries, including Prime Minister Edward Heath and teams from abroad, consistently faced ‘half-hearted understanding rather than fervent support’ from local general psychiatrists.²⁰⁴ The precise level of resources was probably less important than local colleagues’ willingness to offer a commensurate share of them.²⁰⁵ Reflecting this, the GPOA commented that psychogeriatricians’ roles included:

occasional militancy ... to gain a fair share of scant resources, to put them to best use, to make do with too little while wheeling, dealing, and fighting for more.²⁰⁶

RCPsych assessors on consultant appointment committees between 1980 and 1986 had reservations about 20% of successful candidates to psychogeriatric posts, but that was no worse than in other smaller psychiatric specialties.²⁰⁷ Thirty *per cent* of psychogeriatric posts could not be filled. It is unclear how much this reflected insufficient allocation of dedicated SR training posts combined with high numbers of advertised consultant posts, or poor quality applicants, lack of interest or other factors.²⁰⁸ Between 1985 and 1987, RCPsych monitoring noted that standards of applicants for psychogeriatric consultant posts were improving.²⁰⁹

²⁰³ Arie, cited in: Anon. ‘Meeting’ 515

²⁰⁴ Ingeborg Williams, ‘Experiences and reflections of a newly retired psychogeriatrician’ *SPOA Newsletter* (Summer 1981) 2-11 4, 5, 8

²⁰⁵ Arie to DMD White, letter, 23.2.1976 (TA)

²⁰⁶ GPOA, ‘Group into Section?’ 3 (PJ)

²⁰⁷ Peter Brook, ‘Assessors reports on advisory appointments committees: changes since 1974’ *Psychiatric Bulletin* (1989) 13: 16-19 17

²⁰⁸ *Ibid.*; David Jolley, ‘England expects: more than we can provide’ *Psychiatric Bulletin* (1989) 13: 248-249; Manpower Committee, minutes, 11.10.1984, 15/84.a.vii. (RCPsychA)

²⁰⁹ Brice Pitt, ‘Trends in the quality of applicants for consultancies in the psychiatry of old age’ (RCP, MS4811)

Gradually, more consultant psychogeriatrician posts were advertised by local health authorities²¹⁰ and appointments made, suggesting that benefits accrued from the services they provided.

Providing services: in-patient and long-stay facilities

In 1973, a joint geriatric-psychogeriatric planning group voiced concerns about psychiatric hospitals closing without provision of suitable alternative accommodation.²¹¹ In 1976 the DHSS stated that ‘the run-down of mental hospitals ... should not exceed the pace at which special units could be provided’ for older people suffering from severe ‘mental infirmity’.²¹² A DHSS paper written for a conference in 1977 concurred: ‘in some areas bed-closure programmes are out of phase with the development of alternatives’.²¹³ It did not propose solutions.

Evidence for a lack of accommodation, with inadequate plans to remedy the deficit, can be drawn from several sources. For example, DHSS designs for DGH psychiatric units in 1973, failed to mention older people who might require domestic adaptations to maximise independent living if they also suffered physical impairments.²¹⁴ The Worcester Development Project, a feasibility study of comprehensive community and DGH mental health services to replace a local psychiatric hospital began around 1968²¹⁵ and did not automatically include older people.²¹⁶ They were eventually included, since the DHSS feared that otherwise ‘the whole project would be wide open to severe criticism’,²¹⁷ although by who was unclear. Nevertheless, the RHB proposed

²¹⁰ Jolley, ‘England expects’

²¹¹ BGS/RCPsych, ‘Joint report’ 3

²¹² DHSS, *Priorities*, 44

²¹³ DHSS, ‘Conference on the elderly’ 26.7.1977, ‘Background paper’ 8 (PJ)

²¹⁴ DHSS, *Department of Psychiatry (Mental Illness) for a District General Hospital* (London: HMSO, 1973)

²¹⁵ R Turner, G Roberts, ‘The Worcester Development Project’ *BJPsych* (1992) 160: 103-107

²¹⁶ JM Foster to Mr Littlewood, DHSS internal memo, 14.8.1969 (TNA, MH 166/583)

²¹⁷ DHSS, ‘Office Meeting’ Worcester Development Project, 12.7.1973, 2 (TNA, MH 154/953)

that constructing older people's accommodation should be delayed until 1985 after completing all other building.²¹⁸ From the archives available, it is unclear when purpose built accommodation was completed.²¹⁹ While they were waiting, older people were offered second best accommodation deemed surplus to the needs of younger patients. It was cramped, afforded poor observation of patients, had a confusing layout and inappropriate sanitary facilities and did not offer a homely environment suitable for long-stay care.²²⁰ Little attention was paid to recommended innovative architectural designs to promote independence and quality of life for older people with mental disorders.²²¹

Local authority residential homes

HM (72)71 suggested the provision of local authority residential homes at 'an overall ratio' of 25 places per 1000 people over 65 years. The proportion of places for people with mental illness was not specified although people with 'mild' dementia were included.²²² Residential homes would enable many older people to leave long stay back wards, although others would require greater levels of support than residential homes could provide.²²³ In an editorial in 1973 Arie queried whether local authorities could fund sufficient homes within a reasonable time frame with appropriate quality of staff and environment to maximise independence and choice.²²⁴ A report for the Cabinet commented: 'in 1976-77 English local authorities should have opened 1,750 more residential places than they did'.²²⁵

²¹⁸ EJ Lidbury (Birmingham RHB) to Mr Greenaway (DHSS), letter, 15.11.1973, 2 (TNA, MH 154/953)

²¹⁹ Worcester Development Project (TNA, MH 154/953)

²²⁰ Paul Rooney, Rowan Matthews, *Worcester Development Project: psychiatric provision - where do we go from here?* (London: HMSO, 1982) 2.3.2

²²¹ Mick Kemp, DHSS architect, 'Accommodation for elderly patients with severe dementia' Typescript attached to GPOA minutes, 28.3.1974 (RCPsychA)

²²² DHSS, HM (72)71, 8

²²³ Arie, 'Morale' 168

²²⁴ Arie, 'Psychogeriatrics' 195

²²⁵ Home Office, 'Expenditure' 2-3

Standards of residential homes were often poor. At the end of the 1960s, some, which were former public assistance institutions, still segregated men and women, had communal bathrooms, large dormitories rather than individual bedrooms, and lavatories ‘without seats or doors’.²²⁶ About 6,000 places in these older institutions remained; ‘only a handful’ were predicted to close by 1980.²²⁷

There were valid but conflicting opinions on the best options for care, either domiciliary or residential. For example, for very vulnerable mentally impaired people, especially those ‘living in the past’, some psychiatrists preferred domiciliary care, emphasising the inhumanity of removing people from their familiar home environment.²²⁸ Others emphasised the need to provide humane and homely long-stay institutional care for those with a similar degree of impairment.²²⁹

Concerning long-stay institutional care for people with dementia, the moral principles behind integrated or segregated facilities were debated. Social scientists were said to ‘shrink from medical labels and segregation’,²³⁰ although in 1965 the Ministry of Health acknowledged that some people were so disturbed that they could not live amicably with mentally well residents.²³¹ Integration was an obvious way to avoid recreating mental hospital-like institutions, but evidence supporting it was contradictory. In integrated homes, some mentally well residents complained that personal freedom was restricted in the interests of safety for all,²³² and some reports indicated that pressure to

²²⁶ Anon, in MoH files ‘Former Public Assistance Institutions: “Standards” of accommodation’ (1967) 1, 4 (TNA, MH 154/511)

²²⁷ DHSS, ‘Group planning statement 1976/7, Group 7 – the elderly’ second draft, 2 (TNA, MH 154/985)

²²⁸ Alex Baker, ‘Slow euthanasia – or “she will be better off in hospital”’ *BMJ* (1976) ii: 571-572

²²⁹ ‘Admission of old people to hospital’ *BMJ* (1976) individual letters from: David Jolley, Felix Post, SLH Smith, ii: 696; R Tepper, A Campbell, ii: 812-813; Muir Gray, ii: 1007

²³⁰ GPOA, minutes, 24.4.1975, 5.c. (RCPsychA)

²³¹ MoH, *Care of the Elderly in Hospitals and Residential Homes* HM(65)77 (London: HMSO, 1965)

²³² Paul Harrison, ‘The old under control: a case study’ *New Society*, 31.1.1974, 249-252 252

remove confused people from homes was more likely to come from fellow residents than staff.²³³ Conversely, social scientists observed that mentally well people in integrated residential homes were remarkably tolerant of confused fellow residents, despite irritation with their disturbed behaviour. However, that finding may have arisen if residents offered researchers socially acceptable rather than genuine responses to their questions, a possibility suggested in a study by Michael Meacher, a social scientist and Labour MP.²³⁴ There was also the risk that, with more people moving into homes when psychiatric hospitals closed, mentally well individuals might become a minority within the homes which could prove intolerable for them.

Segregated homes had other difficulties, especially when inadequately trained staff worked solely with disturbed people in isolated units. The warden of one such home, Orchard House, in Oxford was imprisoned on charges of grievous bodily harm and assault of residents.²³⁵ It prompted the GPOA to comment: 'there but for the grace of God' went many of the homes in their own areas,²³⁶ suggesting that it was not an isolated occurrence. Quality of care was not always ideal, or even respectful. For example, day-to-day choices, considered integral to self respect and autonomy for an individual in their own home, were not necessarily offered to older people in long-stay care accommodation. This included having and wearing one's own clothes. The *Lancet* reported in 1980 on a scheme in Greater Manchester to provide personalised clothes to long-stay patients, though underwear was still provided from a pool.²³⁷ One psychologist recalled her shock at working in an institution where all the residents' birthdays in any one month were celebrated with a single party, rather than on their individual birthdays.²³⁸ Such observations implied that institutional care and respect for dependent older people was neither dignified nor individual by

²³³ GPOA, minutes, 24.4.1975, 5.c. quoting Dr Thompson (RCPsychA)

²³⁴ Michael Meacher, *Taken for a Ride: Special residential homes for confused old people: a study of separation in social policy* (London: Longman, 1972) 154

²³⁵ Harrison, 'The old' 249

²³⁶ GPOA, minutes, 28.3.1974, 4 (RCPsychA)

²³⁷ Anon. 'Personal clothing for long-stay patients' *Lancet* (1980) ii: 377-378 377

²³⁸ Sara Turner, interview by author (2010)

contemporary standards. Changing the environment from large psychiatric hospitals to more homely community facilities did not necessarily improve care. Bergmann remarked that the differences amounted to ‘sweeping it under one big carpet or hundreds of small rugs’.²³⁹

In 1976, GPOA minutes noted the DHSS’s suggestion that residential homes should move away from medical and nursing styles of care.²⁴⁰ This seemed to imply that trained staff were expensive and untrained staff would be cheaper. The GPOA feared that untrained staff might not meet the needs of more dependent or disturbed residents with dementia. As Pitt observed, staff ‘do not know how to approach or handle them. Trial and error methods sometimes aggravate the condition’.²⁴¹ Training was needed to manage behavioural disturbances, including knowing when to refer to the GP or the psychiatric team for specialist interventions. The DHSS acknowledged in 1978 ‘the deplorable lack of suitably trained staff in old people’s homes’.²⁴² McDonald commented that skills ‘gathered by painful experience in Mental Hospitals’ should be brought ‘into these Residential Homes and prevent the awful mistakes of institutionalisation occurring there’.²⁴³ The RCPsych encouraged directors of social services to liaise with psychogeriatricians in planning and building specialist care homes.²⁴⁴

Community Hospitals

The *Hospital Plan* in 1962 had referred vaguely to ‘many small hospitals’ in addition to DGHs.²⁴⁵ Small hospitals were alluded to in HM (72)71, but whether they were traditional cottage hospitals, proposed ‘community hospitals’ or something different, is unclear.²⁴⁶ Community hospitals were

²³⁹ Bergmann, ‘Witness’ 62

²⁴⁰ GPOA, minutes, 16.9.1976, 7 (RCPsychA)

²⁴¹ GPOA/Pitt, ‘Royal Commission’ (PJ)

²⁴² Tony Lynes to Malone Lee, (DHSS internal memo) 11.4.1978 (TNA, MH 154/1068)

²⁴³ McDonald, ‘Responsibility for graduate population’ 3

²⁴⁴ RCPsych, ‘Residential homes for the elderly mentally infirm’ (1976) EFCC21/76, C42/76, 3 (PJ)

²⁴⁵ MoH, *Hospital Plan*, 7

²⁴⁶ DHSS, HM (72)71, 6

formally announced in 1973 after little consultation and minimal pilot studies.²⁴⁷ Details were outlined in a Government memorandum obtained by the GPOA, officially stamped 'For information only'. It indicated that they would provide accommodation for people with dementia requiring 'hospital care and treatment', i.e. those with more severe forms of the disorder or difficult behaviours.²⁴⁸ Psychogeriatricians and geriatricians were concerned about these plans.²⁴⁹ There was no indication that appropriately trained nurses would be available to care for the 'difficult demented'.²⁵⁰ Bergmann wrote: 'the community hospital, whatever that may be. Is it perhaps the old workhouse? The half-empty tuberculosis hospital?'²⁵¹ The DHSS commented that 'the use of existing buildings may enable some community hospitals to be established early'.²⁵² This provoked the response from the GPOA that 'someone is trying to run this on the cheap',²⁵³ and that older people with dementia were being offered second class, discarded or obsolete facilities which were unlikely to promote their independence.²⁵⁴ By contrast, there were no plans to place younger, mentally ill people in these community hospitals.²⁵⁵ Arie commented:

if community hospitals become largely aggregations of patients who do not merit the services of the DGH we can expect to see in them something very similar to the institutions we have come to know so well.²⁵⁶

Community hospitals did not become widespread. They are important in this study because of the insights they give into planning services. Brothwood was dubious about their benefits. The GPOA secretary minuted Brothwood's view:

²⁴⁷ JA Oddie, JC Hassler, SM Vine, AE Bennett, 'The community hospital: a pilot trial' *Lancet* (1971) ii: 308-310

²⁴⁸ DHSS, *Community Hospitals: their role and development in the National Health Service* (DHSS, 1974) 4

²⁴⁹ BGS/RCPsych, 'Joint report' (1973) 3

²⁵⁰ GPOA, draft minutes, 30.1.1975, 5.g. (PJ)

²⁵¹ Klaus Bergmann, 'Psychogeriatric services' *NN* (Aug. 1973) 6-8 7

²⁵² DHSS, *Community Hospitals*, 7

²⁵³ GPOA, minutes, 30.1.1975, 'reminder notes' 5.g. (PJ)

²⁵⁴ GPOA, minutes, 28.3.1974, 13; 13.6.1974, 4; 19.1.1978, 17/78 (RCPsychA)

²⁵⁵ DHSS, *Community Hospitals*, 10

²⁵⁶ Arie, 'Psychogeriatrics' 195

‘Policy has outstripped experience’,²⁵⁷ suggesting that DHSS uncertainty may have contributed to non-implementation of their own proposals.

Providing services: domiciliary and community support for people at home

In 1976 the DHSS estimated that there were 16,000 elderly people ‘with severe mental infirmity’ in psychiatric hospitals, but possibly over 650,000 with some degree of mental infirmity in their own homes, with relatives, or in residential homes in the community.²⁵⁸ A greater proportion was estimated to be living in their own homes than Kay *et al* had identified in 1964, even allowing for different methodologies.²⁵⁹

Social changes affecting care in the community, such as the employment patterns of women, received little real consideration. Expectations of older people were changing, for example, remaining longer in their own homes; people entering institutions were older and had greater care needs than previously.²⁶⁰ To achieve humane hospital closure, schemes similar to those piloted with good effect since the 1950s on a small scale, such as Cosin’s or DeLargy’s day hospital plus respite admissions, or Whitehead’s comprehensive approach,²⁶¹ needed wider implementation. Planning domiciliary care and new institutions located close to the person’s home required multi-agency cooperation. Although some senior doctors and directors of social services collaborated on strategic planning,²⁶² schemes to support individuals in the community developed only slowly.

There were numerous suggestions for community support to enable discharge or prevent admission of older mentally ill people by enhancing their wellbeing

²⁵⁷ GPOA, meeting, 30.1.1975, secretary’s notes, 5.g. (PJ)

²⁵⁸ DHSS, *Priorities*, 40

²⁵⁹ Kay, ‘Study of prevalence’ 152

²⁶⁰ Henry Yellowlees (CMO) to AG Parkes, (Chairman, BMA Joint Consultants Committee) letter, ‘Residential homes for the elderly - arrangements for health care’ 27.5.1976 (PJ)

²⁶¹ e.g. Whitehead, *Service of Old Age*; DeLargy, ‘Six weeks in’

²⁶² Anon. ‘Management of the demented patient in the community’ *NN* (Feb. 1976) 3; GPOA, ‘Memorandum on residential homes for the elderly mentally infirm’ *NN* (Sept. 1976) 10-12

and supporting their families. These were unevenly provided but included boarding out, day centres and clubs, sheltered workshops, meals-on-wheels, home helps, 'sitters', laundry services, a 'good neighbour policy', and financial support for families caring for older people.²⁶³ One alternative to long-stay care for people with dementia was living at home and attending a day hospital.²⁶⁴ The focus was on care rather than active treatment. Day hospitals for older people requiring active treatment and more intensive support than outpatient clinics could provide were unusual. The idea of providing specific treatment opportunities similar to those for younger people was still not universal. Older mentally unwell people were unlikely to be admitted to general psychiatry or geriatric day hospitals. In one study of patients attending geriatric day hospitals, 4% had a primary diagnosis of depression and 4% of dementia.²⁶⁵ Of the geriatric day hospital nurses questioned in that study, 'most emphasised that the proportion of demented patients should be kept low'.²⁶⁶

Whitehead noted in 1970 that 'Some patients enjoy the ambulance journey more than the session in the day hospital'.²⁶⁷ In 1975, Arie jokingly suggested 'transport therapy', whereby the journey and activities on board were the focus of therapy.²⁶⁸ At least one foreign visitor to his unit took the suggestion literally and asked for more information about the scheme.²⁶⁹ Yet for many patients the journey to the day hospital was the only glimpse of life outside an otherwise house-bound world. Despite the intrinsic value of the journey, a lack of suitable transport to take people to and from the day hospital often limited the availability of day places,²⁷⁰ and the cost of transport was a well recognised

²⁶³ Enoch and Howells, *Organisation*, 11

²⁶⁴ Peter Jefferys, Bob Papp, Sue Barrett, Rosemary Jennings, Jane Savage, 'The Herga Centre – a NHS run day centre for confused elderly people' 1-9. In: *Approaches to Day Care for Elderly People who are Mentally Infirm* (MIND, 1979)

²⁶⁵ John Brocklehurst, J Tucker, *Progress in Geriatric Day Care* (London: King Edward's Hospital Fund for London, 1980) 104

²⁶⁶ *Ibid.* 94-95

²⁶⁷ Whitehead, *Service of Old Age*, 82

²⁶⁸ Tom Arie, 'Day care in geriatric psychiatry' *Gerontologia Clinica* (1975) 17: 31-39 37

²⁶⁹ Arie, 'Day care 1978' 90

²⁷⁰ Colin Godber, cited in Anon. 'Meeting' *BJPsych* (1978) 132: 514-515 514

disincentive to creating more day hospitals.²⁷¹ By 1978, very few places reached the government's 1972 targets for day hospital places.²⁷²

Living at home with dementia: supporting the carers

The importance of supporting carers of people with dementia was well recognised.²⁷³ It was becoming more widely discussed, including in parliament.²⁷⁴ The need for carer support was evident in the origins of the Alzheimer's Society. This charity was founded by two women with experience of caring for relatives with dementia.²⁷⁵ They wanted to improve the quality of care, support and information available for people with dementia and their carers. They worked collaboratively with psychogeriatricians and others to achieve this.²⁷⁶ *The 36-hour Day*, a book about caring for people with dementia in their own homes, was aptly named.²⁷⁷

It was expected that women would automatically take on carer roles, usually unpaid. Many wanted, or felt obliged, to fulfil these roles despite other commitments, often fitting their caring duties around paid employment. They hugely subsidised statutory services, by £3.7 billion a year, a conservative estimate, when the total annual expenditure on health and personal social services for people over 75 was £3.9 billion.²⁷⁸ Until the mid 1980s, married and cohabiting women were excluded from the meagre Invalid Care Allowance paid to other carers who were not otherwise earning.²⁷⁹ Thus many informal

²⁷¹ Arie, 'Day care 1978' 90; DN Ross, 'Geriatric day hospitals: counting the cost compared with other methods of support' *Age Ageing* (1976) 5: 171-175; Farndale, *Day Hospital*, 77

²⁷² DHSS, HM (72)71, 10; Arie, 'Day care 1978' 88

²⁷³ e.g. DeLargy, 'Six weeks'; Jacqueline Grad, Peter Sainsbury, 'An evaluation of the effects of caring for the aged at home' 225-236. In: WPA, *Psychiatric Disorders*

²⁷⁴ Richard Holt, John Patten, 'Alzheimer's Disease' HC Deb 9.4.1984 *Hansard* Vol. 58 cc173-178 http://hansard.millbanksystems.com/commons/1984/apr/09/alzheimers-disease#S6CV0058P0_19840409_HOC_675 accessed 26.3.2013

²⁷⁵ Alzheimer's Society, 'Our history'

²⁷⁶ Graham, 'Witness' 64-65

²⁷⁷ Nancy Mace, Peter Rabins *et al.* *The 36-hour Day: caring at home for confused elderly people* (London: Hodder and Stoughton with Age Concern, c.1985. UK edition, adapted from US edition. Baltimore: Johns Hopkins Press, 1981)

²⁷⁸ Henwood and Wicks, *Forgotten Army*, 13

²⁷⁹ Audit Commission, *Making a Reality*, 44

carers received little financial help and almost no training or professional advice about managing the illnesses of the person they cared for.²⁸⁰

Failure to provide services risked leaving families struggling to cope.²⁸¹ The HAS noted that: ‘with the right kind of help a family continues to manage. Without, it may despair and insist that the statutory bodies take over’.²⁸² At that point, social crises or minor physical illness could lead to medically unnecessary admissions to expensive and over-stretched hospital beds. Lack of support for exhausted carers unable to cope with a person who was already extremely frail or close to death probably contributed to the situation described in the *BMJ* in 1986, indicating that older people who had unplanned hospital admissions for which no acute physical cause was identified had high death rates.²⁸³ The report received much publicity.²⁸⁴

Psychogeriatric teams aimed to ameliorate difficult behaviours associated with dementia, particularly those which distressed the patient and impacted on carers. These included verbal abuse, aggression, incontinence, faecal smearing, wandering, difficulty in eating and restlessness day and night.²⁸⁵ Such behaviours made clear why the SPOA and those advocating for older mentally ill people were uneasy with the government’s emphasis on family carers, voluntary organisations, and neighbourhood networks rather than statutory services proposed in earlier DHSS guidelines.²⁸⁶ One geriatrician commented

²⁸⁰ Robert Anderson, ‘The unrelenting burden on carers’ *BMJ* (1987) 294: 73-74; DA Jones, NJ Vetter, ‘Formal and informal support received by carers of elderly dependents’ *BMJ* (1985) 291: 643-645

²⁸¹ DHSS, *Growing Older*, 43; Shegog, ‘Conclusions’ 7-26 15; Peter Millard, ‘Last scene of all’ *BMJ* (1981) 283: 1559-1560

²⁸² HAS, *The Rising Tide: developing services for mental illness in old age* (Surrey: NHS HAS, 1982) 3

²⁸³ G Rai *et al.* ‘Hazards for elderly people admitted for respite (“holiday admissions”) and social care (“social admissions”)’ *BMJ* (1986) 292: 240; Judith Oliver, ‘Hazards for elderly people admitted for respite and social care’ *BMJ* (1986) 292: 481

²⁸⁴ Oliver, ‘Hazards’

²⁸⁵ Anderson, ‘Unrelenting burden’; N Argyle, S Jestice, CPB Brook, ‘Psychogeriatric patients: their supporters’ problems’ *Age Ageing* (1985) 14: 355-360 357

²⁸⁶ e.g. DHSS, HM (72)71

that the ‘ultimate protest’ at being unable to cope with the caring role was murder.²⁸⁷

The Rising Tide initiative

Meetings about the future of psychiatric services acknowledged that they ignored ‘especially psychogeriatrics’, risking creating plans which neglected older people.²⁸⁸ This recalled the absence of psychogeriatric and geriatric specialists on earlier committees planning old age services, with the implication that the opinions of the doctors in the field were of secondary importance.²⁸⁹ Hence, in 1982, it was an important step when interested and involved protagonists came together with the aim of improving and expanding psychogeriatric services under the auspices of the HAS. This initiative came to be known by the title of its report, *The Rising Tide*. Its conclusions resulted from over a decade of multi-disciplinary HAS inspections, plus a three day workshop which included delegates from the DHSS, social services, hospitals, general practice, public health and voluntary organisations.²⁹⁰

From the vantage point of the psychogeriatricians, *The Rising Tide* contained little that was new, although the multi-disciplinary method by which it was derived added strength to earlier, medically-led arguments. *The Rising Tide* emphasised the need to provide for all mental illnesses in old age, not just dementia.²⁹¹ This suggests that assumptions were still being made that functional illness in old age, for example depression, was ‘normal’ or ‘understandable’ so nothing need be, or could be, done about it, or that older people’s needs were identical with those of younger people and so should be treated by specialists working across all age groups.

²⁸⁷ Millard, ‘Last scene’

²⁸⁸ Robin Steel, ‘Psychiatric disorders in general practice’ *Journal of the Royal College of General Practitioners (JRCGP)* (1981) 31: 765-766; Annie Altschul, ‘Psychiatric nursing in Great Britain’ Lecture, Madrid, 1983 (RCNA, C305/1/2)

²⁸⁹ Bethlem-Maudsley Medical Committee, minutes, 26.10.1970, ‘Community Services Centre’, MCD96/70, MCM 112/70 (BRHA); BMA, Geriatrics Joint Sub-committee, agenda, 24.2.1954 (BMAA)

²⁹⁰ HAS, *Rising Tide*, 1

²⁹¹ *Ibid.* 2

The Rising Tide proposed expanding recognised good practice – comprehensive multi-disciplinary and multi-agency team work, short-term and long-term treatment in in-patient and community locations – under the leadership of psychogeriatricians who took responsibility for, not just an interest in, older people.²⁹² In the context of Griffiths’ introduction of general management to the NHS, this might be difficult. Managers might pressurize unresponsive consultants to do more, but the system risked jeopardising novel problem-solving schemes usually created by experienced senior frontline clinicians who were leading and inspiring successful teams.

Deriving from *The Rising Tide*, the DHSS in 1982 allocated £6 million start-up money for ‘demonstration districts’ proposed by Norman Fowler, Secretary of State for Social Services. These districts would display well developed integrated services and ‘would be a centre for information and for training of staff in its region’.²⁹³ This caused a furore among psychogeriatricians because Fowler’s plans implied additional funding for districts which were already significantly better resourced and providing services, and less for those with nothing to demonstrate. Arie and Jolley, writing in the *BMJ*, wanted funding to be allocated on the basis of proposals, to emulate as well as to demonstrate: ‘What we need is “development”, and the fudging of the distinction between “development” and “demonstration” mars this important initiative’.²⁹⁴ These disagreements may have reflected inadequate communication between the DHSS and the SPOA. They left a lingering discomfort among some psychogeriatricians.²⁹⁵

Ultimately, spurred on by the offer of funds, many regions submitted multiple applications to the DHSS with plans to initiate local services.²⁹⁶ The large

²⁹² *Ibid.* 11

²⁹³ Norman Fowler, ‘Welfare state’ HC Deb 8.11.1982 *Hansard* Vol. 31 c.330 <http://hansard.millbanksystems.com/commons/1982/nov/08/welfare-state> accessed 13.2.2013

²⁹⁴ Tom Arie, David Jolley, “‘The Rising Tide’” *BMJ* (1983) 286: 325-326 325

²⁹⁵ Arie, e-mail, 30.1.2011

²⁹⁶ DHSS, *District Services for Mental Illness in Old Age Demonstrating Development, 1983: proposals submitted by RHAs* (London: DHSS, 1983)

number of applications for funding indicated the interest and ability of local health and social services to identify needs which required attention, but also pointed to obstacles, perhaps due to reluctance or the perceived impossibility, of providing services without additional financial stimulus. Although most applications failed to gain funding, having invested time in considering and planning their schemes, most implemented them.²⁹⁷ Overall investment was far greater than the £6 million originally allocated.²⁹⁸ The cost of many initiatives was borne by locally sourced money transferred within existing health and social care budgets. This reinforced awareness of the potential for identifying local funding which could be reinvested in old age services, rather than requiring additional government funding. This was a double-edged sword: reinvestment was essential, but so was new funding, which could easily be overlooked if the former was perceived as adequate and feasible. Fowler achieved his goals of 'initial extra money ... to get things moving',²⁹⁹ with remarkable and unpredicted effect.

The Rising Tide attracted little national interest. The media seemed uninterested in the plans or in local innovations, in keeping with its broad disregard of older people. As Donald Dick, director of the HAS, reflected, the press launch of the initiative

fell somewhat flat, and earned far less national coverage than the tale of an exploding tin of black treacle which broke on the same day! ... There is no doubt in my mind that the government had a very good deal from its seed money.³⁰⁰

Research and evaluating services

The value of a medical specialty is related to its effectiveness in diagnosing and treating illness. Developing and measuring this effectiveness required various sorts of research, but catchment area based clinical service evaluation was

²⁹⁷ Dick, 'Rising Tide initiative' 17

²⁹⁸ Richard McNally, '£6 million: value for money?' 19-23. In: *Developing Services* ed. Bernard, 22

²⁹⁹ Fowler, *Hansard*, 8.11.1982

³⁰⁰ Dick, 'Rising Tide initiative' 17

particularly important for validating service models relevant to policy making and could be carried out by local psychogeriatricians.

Evidence of the benefits of psychogeriatric provision was accumulating, but research was hampered by the high clinical workload of psychogeriatricians.³⁰¹ They

have been engulfed in administrative problems and have had little time, energy or inclination to concern themselves with research, which has often been seen as something of a luxury³⁰²

stated Raymond Levy, professor of psychogeriatrics at the Bethlem-Maudsley and Institute of Psychiatry. Some, however, managed the important tasks of innovating and evaluating services and analyzing the feasibility and effectiveness of new approaches.³⁰³

In the 1980s, problems identified in earlier studies were further investigated, for example, stresses on carers;³⁰⁴ disabilities of people living in care homes;³⁰⁵ psychiatric morbidity among general hospital medical and surgical in-patients;³⁰⁶ the outcomes of treatment for older people suffering from depressive illness.³⁰⁷ Results added to knowledge and usually corroborated earlier observations. One aspect of care which was difficult to evaluate was the patient's experience of services. Under-evaluation was probably linked to disregard of their views and to qualitative methods in medical research being

³⁰¹ SPOA, minutes, 17.12.1987, 47EC/87 (RCPsychA)

³⁰² Raymond Levy, 'Obstacles to research in geriatric psychiatry' *IJGP* (1986) 1: 83-84 83

³⁰³ HAS, *Rising Tide*, 34; D Gaspar, 'Hollymoor Hospital dementia services: analysis of outcome of 230 consecutive referrals to a psychiatric-hospital dementia service' *Lancet* (1980) i: 1402-1405

³⁰⁴ Chris Gilleard *et al.* 'Emotional distress amongst the supporters of the elderly mentally infirm' *BJPsych* (1984) 145: 172-177

³⁰⁵ Clarke, 'Patterns of disability'

³⁰⁶ HR Millar, 'Psychiatric morbidity in elderly surgical patients' *BJPsych* (1981) 138: 17-20

³⁰⁷ Robert Baldwin, David Jolley, 'The prognosis of depression in old age' *BJPsych* (1986) 149: 574-583

poorly established.³⁰⁸ However, the opinions of patients and carers in the report on the ‘travelling day hospital’ (a team of staff who ran their day hospital in a different location each weekday in order to facilitate patient access) in Hampshire, reinforced the benefits of treatments and community services, including helping with rebuilding confidence, unburdening of worries, developing new interests in life and having activities to look forward to.³⁰⁹ Evaluations of community and hospital psychogeriatric services by independent experts such as the Centre for Policy on Ageing (CPA) also reached positive conclusions.³¹⁰

Establishing academic standing

Most medical schools had departments of psychiatry by 1970, almost half of which were headed by professors.³¹¹ In 1981, 14 of the 30 medical schools in Britain had academic departments of geriatric medicine, of which 12 had professors.³¹² Psychogeriatrics was far behind. In terms of the body of knowledge in the field and demographic demands it was difficult to argue that academic leadership and university psychogeriatric departments were less necessary than for other specialties. Arie was the first psychogeriatrician to be appointed professor (1977), but that was to a Chair of Health Care of the Elderly, not psychogeriatrics.³¹³ The first professors of psychogeriatrics were Elaine Murphy and Raymond Levy appointed in 1983, then Brice Pitt in 1985.³¹⁴ By 1989, the ratio of professors to consultants in psychogeriatrics was

³⁰⁸ Catherine Pope, Nick Mays, ‘Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research’ *BMJ* (1995) 311: 42-45 42-43

³⁰⁹ Neil Evans *et al.* *Something to Look Forward to -- an evaluation of a travelling day hospital for elderly mentally ill people* (Portsmouth: Social Services Research and Intelligence Unit, 1986) 188-198, 190-191, 195

³¹⁰ Alison Norman, *Mental Illness in Old Age: meeting the challenge* (London: CPA, 1982) 121

³¹¹ *Medical Directory* (London: JA Churchill, 1970) 2: 3105

³¹² R Smith, B Williams, ‘A survey of undergraduate teaching of geriatric medicine in the British medical schools’ *Age Ageing* (1983) 12: Supplement: 2-6 2-3

³¹³ Tom Arie, Elaine Murphy, ‘A conversation with Tom Arie’ *IJGP* (1996) 11: 671-679 678

³¹⁴ SPOA, minutes; 22.9.1983, 25SPOA/83, Elaine Murphy, Guy’s; 1.12.1983, 36SPOA/83, Raymond Levy; 5.12.1985, 46EC/85.a. Brice Pitt, St Mary’s and Royal Postgraduate Medical School (RCPsychA)

one to 50; in general psychiatry it was one to 20.³¹⁵ Even if total appointments could have been expected to be lower for a smaller and newer specialty, the ratios within the different specialties should have been similar. The low proportions may have been due to a genuine lack of suitably trained academic clinicians, but it was also likely to have been related to psychogeriatrics not being regarded by senior academic leaders as a serious discipline. Williamson alleged that ‘the universities’ door wasn’t open’.³¹⁶

Research and teaching

Academic departments could ensure dedicated time and expertise for research and teaching. In contrast to service evaluations, clinical and scientific research undertaken in university departments outside individual locality services might include epidemiological investigations, controlled pharmacological or other intervention studies, and evaluating new diagnostic techniques such as brain scans. These would ultimately underpin clinical practice likely to affect the treatment offered within clinical services rather than the model of service provision directly.

UK government funding for universities was significantly reduced in the 1980s, and medical and scientific research funding for major studies was harder to obtain. Psychiatry generally had difficulty competing with other medical specialties, partly attributed to the newness and small size of their academic departments especially compared to medicine and surgery.³¹⁷ For psychogeriatrics, new voluntary sector pressure groups, such as the Alzheimer’s Society, were not yet able to provide funding and had hardly started lobbying the government to do so.

The General Medical Council’s guidance in 1980 on training medical students took a broad perspective on old age health care, physical and mental,

³¹⁵ RCP/RCPsych, *Care of Elderly People*, 4

³¹⁶ Williamson, ‘Witness’ 27

³¹⁷ Robert Kendell, ‘The future of psychiatric research in Britain’ *BMG* (1987) 34: 3: 24-25 24

institutional and community.³¹⁸ Good old age teaching and rewarding clinical attachments could improve students' attitudes towards older people and influence their career choices.³¹⁹ In 1985/6, despite a shortage of academic staff, there was psychogeriatric teaching at all UK undergraduate medical schools, with a mean of six days clinical experience and 3.4 hours of lectures, an overall increase compared to previous reports.³²⁰

Psychogeriatricians were keen to know about each others' teaching activities. A postal survey of colleagues in 1984 by Arie *et al* had a very high response rate, 171 of 199 (86%),³²¹ significantly higher than the usual 50-60% expected for postal surveys to doctors in the UK.³²² Some psychogeriatricians had an enormous teaching commitment, taking into account their weighty clinical responsibilities. Some taught trainee nurses and doctors more than 100 hours annually. Taking individual students on domiciliary visits was labour intensive, requiring enthusiasm and dedication. Much teaching was by consultants in DGHs who were not automatically involved with medical students and may not have been remunerated. Teaching relatives and carers was undertaken by 44% of consultants.³²³ This was particularly important for improving carers' knowledge and skills in managing behavioural, psychological, physical, social and legal challenges of caring for someone with dementia. The level of teaching of staff and carers was high, and reflected the psychogeriatricians' enthusiasm, dedication and desire to spread their knowledge and expertise.

³¹⁸ GMC Education Committee, *Recommendations on Basic Medical Education - issued in pursuance of Section 15 of the Medical Act 1978* (London: GMC, 1980) 23

³¹⁹ Wattis, 'Medical students' attitudes'

³²⁰ John Wattis, 'Old age psychiatrists in the United Kingdom - their educational role' *IJGP* (1989) 4: 361-363 361, 362; Tom Arie, RG Jones, CW Smith, 'The educational potential of old age psychiatry services' 196-206. In: *Recent Advances in Psychogeriatrics* 1. ed. Arie, 198

³²¹ Arie, 'Educational potential' 198

³²² S Cummings *et al.* 'Reported response rates to mailed physician questionnaires' *Health Services Research* (2001) 35: 1347-1355 1347

³²³ Arie, 'Educational potential' 198

Conclusions: services towards the end of the 1980s

Fig 17. York: a psychogeriatric service map, 1985

Source: Beryl Bromham, 'A psychogeriatric unit in North Yorkshire' *SPOA Newsletter* (1985) 7: 14-17 16a (Reproduced with permission of the editor, David Jolley)

Wattis's surveys highlighted the spectacular increase in dedicated provision across the country.³²⁴ In 1985/6 his postal survey of psychogeriatricians had an 83% (281 of 338) response rate.³²⁵ It identified over 200 consultant psychogeriatricians, each working at least 2½ days a week, in specialist services (Table 5).

Table 5. Number of consultant psychogeriatricians (minimum 5 sessions³²⁶ / week) in UK

Year	Consultants
1969	8
1970	12
1974	35
1980	120
1984	180
1986	205
1989	280
1993	405

Source: Arie and Jolley, 'Psychogeriatrics' 262

Wattis, by his spurious use of statistics, commented humorously on the success of psychogeriatrics as a profession:

You could draw a graph which showed that the number of old age psychiatrists was increasing exponentially and by the year 2000 there would be no doctors who were not old age psychiatrists!³²⁷

At the end of 1986, about 70% of the UK population had a specialist psychogeriatric service available (Fig 18, showing England and Wales). Most full-time consultants were supported by junior medical staff, and had a mean of 21 assessment and 74 long stay beds, plus 25 'day places'. Only about one third had assessment beds in DGHs, still too few to facilitate thorough medical investigation of all older people admitted. Twenty-seven reported joint units with geriatricians.³²⁸ Dick's successor at the HAS, Peter Horrocks, commented in 1986 that no single district yet offered the full range of services which he

³²⁴ Wattis, 'National survey' 1529; e.g. SPOA, minutes, 19.5.1983, 14EC/83 (RCPsychA)

³²⁵ Wattis, 'Geographical variations' 172

³²⁶ One 'session' = 3.5 hours

³²⁷ John Wattis, 'Witness' 55

³²⁸ Wattis, 'Geographical variations'; RCP/ RCPsych, *Care of Elderly People*, 3

envisaged as necessary for comprehensive old age health care.³²⁹ This reflected the Health Care Evaluation Research Team's findings in 1974.³³⁰ Dick commented in 1987 that 'wherever services were going well, responsibility was in the hands of named individuals', usually psychogeriatricians, in contrast to circumstances where 'consultant psychiatric staff had declared that the management of dementia was not the responsibility of psychiatrists and provided no service', a response acceptable to some health authorities.³³¹

There were few formal studies comparing the effectiveness for older people of psychogeriatric and 'all-age' psychiatric services. One study conducted in 1985/6 compared 'specialized' and 'non-specialized' services treating older people. Despite difficulties in the sampling method which may have minimised differences, it indicated outcomes 'in favour of the specialized services', such as for teaching, research and having beds in DGHs rather than in psychiatric hospitals.³³² Other comparative studies largely post-date the period covered in the thesis, but support earlier observations of the greater benefit provided by specialist psychogeriatric services.³³³ Methodologically ideal, randomised and double blind studies were lacking, and even well designed studies risked creating artificial environments of case selection, staffing levels and case load.³³⁴ In the 1980s, qualitative evaluation was uncommon and the preoccupation in the NHS with measures of activity rather than clinical outcome did little to promote analysis of effectiveness and efficiency of different service models either directly by the DHSS or by local teams. There

³²⁹ Peter Horrocks, 'The components of a comprehensive district health service for elderly people – a personal view' *Age Ageing* (1986) 15: 321-342 321

³³⁰ Kushlick and Blunden, 'Project' (1974) (PJ)

³³¹ Donald Dick, 'The Rising Tide initiative' 13-18. In: *Developing Services for Elderly Mentally Infirm People: responses to the 'Rising Tide' initiative* ed. Miriam Bernard (Keele: Beth Johnson Foundation Publications, 1987) 15

³³² John Wattis, 'A comparison of 'specialized' and 'non-specialized' psychiatric services for old people in the United Kingdom' *IJGP* (1989) 4: 59-62 59

³³³ Brian Draper, 'The effectiveness of old age psychiatry services' *IJGP* (2000) 15: 687-703; Brian Draper, Lee-Fay Low, 'What is the effectiveness of acute hospital treatment of older people with mental disorders?' *International Psychogeriatrics* (2005) 17: 539-555

³³⁴ Bob Woods, 'Foreword' v-vii. In: Jenny Finch, *Evaluating Mental Health Services for Older People* (Oxford: Radcliffe Publishing Ltd, 2004)

was a need for rigorous, standardised and validated methods to evaluate mental health services for older people.³³⁵

Fig 18. Psychogeriatric services, England and Wales, 1986



Key:
 ■ Health authorities with a 'consultant psychiatrist taking an interest or responsibility for the elderly'
 ● Consultant (minimum 5 sessions / week)
 ● Professor
 Source: David Jolley

³³⁵ Finch, *Evaluating Mental Health Services*

The psychogeriatricians were enthusiastic and idealistic, regarded adversity as a challenge³³⁶ and ‘trouble’ as a ‘teaching tool’.³³⁷ Their passion did not seem to wane, despite setbacks.³³⁸ Unity and moral support were vital to prevent emotional exhaustion. Collegiality was intense and valued, as David and Susan Jolley reflected after the witness seminar in 2008:

after breaks of decades ... there was no sense of discontinuity ... Appearance, dress, posture, facial expression, voice and narrative style and even content all took on as if we had been together yesterday ... The strength of fellowship shared remained evident these thirty years on.³³⁹

Despite the economic situation, reservations from outside the specialty, inconsistent commitment from the DHSS and lack of recognition, the specialty was growing, suggesting significant interest among clinicians and a willingness of local health authorities to create new posts. Psychogeriatricians took pleasure in seeing their specialty expand.³⁴⁰

Provision still lagged unacceptably behind set targets and, by 1990, some social scientists were concerned that individuals’ needs were still not being met.³⁴¹

Wattis commented:

mentally ill old people need a larger slice of a larger cake not the crumbs left under the table after the other areas of medicine have fought over the dry crusts of present funding.³⁴²

³³⁶ David Jolley, ‘Editorial’ *SPOA Newsletter* (1982) 4: 1

³³⁷ Tom Arie, ‘Witness’ 47

³³⁸ Jolley, ‘Editorial’ *SPOA Newsletter* (1982) 4: 1

³³⁹ David Jolley, Susan Jolley, ‘Guthrie Trust Witness Seminar’ (PSSRU: Manchester, 2008) <http://www.medicine.manchester.ac.uk/pssru/newsandevents/gtwseminarsummary.pdf> accessed 14.4.2013

³⁴⁰ David Jolley, ‘Editorial’ *SPOA Newsletter* (1985/6) 8: 7

³⁴¹ Andrew Bebbington, Helen Charnley, ‘Community care for the elderly - rhetoric and reality’ *BJSW* (1990) 20: 409-432

³⁴² John Wattis, ‘Working party on the care of the elderly mentally ill: service recommendations’ (1987) D1JPW-12.87 7-8 (RCPsychA)

Chapter 6

Psychogeriatrics and its partners, participants, opponents and admirers in the 1970s and 1980s

Psychogeriatrics is part of
*the family of psychiatry, married to geriatrics and conducting a fairly
turbulent affair with social services.*

Professor Brice Pitt (before 1985)¹

Psychogeriatrics developed mainly within the field of psychiatry. It necessarily interacted with other medical specialties and with professions such as social work, nursing and psychology. The UK model also achieved international acclaim. These relationships had the potential to influence the development of services and the process of official recognition by the government.

Collaboration and dissent with geriatricians

Older people frequently suffered from psychiatric and physical disorders simultaneously, so good collaboration between psychiatrists and geriatricians, both clinically and in planning services, had the potential to benefit them. Nevertheless, collaboration was not always straightforward. Some clinicians described the need to find ways of ‘dissipating the increasing feeling of geriatricians and psychiatrists, that each is trying to get the other to do their work’.² Antagonism may also have been associated with apprehension about resources, e.g. that the proposed psychogeriatric facilities in the DGHs and the community would never meet demands.³

Clinical collaboration

A few geriatricians were appointed to work in psychiatric hospitals in the 1970s. However, the psychiatrists were reported to have discouraged them, and the lure of the new DGHs for the geriatricians probably outweighed that of the psychiatric hospitals.⁴ Establishing geriatric and psychogeriatric wards in the

¹ Arie, ‘Educational potential’ 206

² Andrews, ‘Planning of psychogeriatric care’ 100

³ *Ibid.* 108

⁴ Denham, interview by author (2007)

same DGH should have simplified and improved collaboration.⁵ However, these were slow to materialise. In 1974 the HAS commented:

psychiatrists and geriatricians sometimes disagree about their responsibilities for individual patients, with the result that both reject the problem and deadlock ensues ... Such lack of joint responsibility can only be deplored.⁶

On these grounds, the HAS reinforced the need to create joint psycho-geriatric assessment units (P-GAUs),⁷ a logical response to their findings, but not in the context of the chequered history of the units. The DHSS, in 1970, had largely reiterated proposals for P-GAUs made in 1950.⁸ They were never widely implemented,⁹ and the DHSS did not appear to seek reasons for it. At the time of the 1970 P-GAU recommendation, the DHSS had already rejected the Severalls scheme¹⁰ and was unaware of Arie's work at Goodmayes.¹¹ Correspondence in the *Lancet*¹² in 1970 suggested some medical interest in establishing them. The DHSS may have thought the original P-GAU proposals still worth implementing, or they may have lacked inspiration to propose anything else. Some of the earlier pitfalls of P-GAUs remained unresolved, such as the asymmetrical availability of interested specialists, with around 240 consultant geriatricians in the UK by 1974¹³ compared to 30-40 psychogeriatricians.¹⁴

⁵ Enoch and Howells, *Organisation* 3

⁶ NHS, *Annual Report HAS*, 30

⁷ *Ibid.* 30

⁸ DHSS, *Psycho-Geriatric Assessment Units*; MoH, *Care of the Aged*

⁹ DHSS, *Psycho-Geriatric Assessment Units*, 3

¹⁰ Brothwood, 'Organisation' 110

¹¹ Arie, e-mail, 23.1.2012

¹² 'Psychogeriatric Assessment Units' *Lancet* (1970) (Letters in response to: Anon. 'Psychiatric assessment of the elderly' *Lancet* (1970) i: 791) James Andrews, i: 1004; HP Burrowes, i: 1121; Norman Exton-Smith and KV Robinson, i: 1292; Lindsay Hurst and Eric Morton, ii: 47-48; Leslie Wilson, ii: 468

¹³ John Brocklehurst, *The Geriatric Day Hospital* (London: King Edward's Hospital Fund, 1970) 17

¹⁴ Arie and Jolley, 'Psychogeriatrics' 262

Despite the HAS's encouragement, predictably few further P-GAUs developed. However, those about which we know seemed to flourish. That might be a bias of the sources, which were peer reviewed medical journals reporting successful practice. The practitioners were sufficiently motivated to analyse outcomes and write up their findings. Successful schemes tended to have leaders of similar mindset and resolve, such as Brice Pitt and Chris Silver in East London,¹⁵ or psychogeriatrician Gordon Langley with his geriatrician colleagues in Exminster, Devon.¹⁶ Perhaps the P-GAU with the most far reaching effect was in Ilford where Arie joined geriatrician Tom Dunn;¹⁷ it laid the groundwork for Arie's joint department of 'Health Care of the Elderly' at Nottingham University Medical School in 1977.¹⁸ Arie's appointment there was unusual. It was a chair for which applications were invited from doctors in any relevant discipline; Arie received significant support in his application from geriatrician colleagues such as Anderson, Exton-Smith and Grimley Evans.¹⁹

Clinicians' enthusiasm was at the heart of joint schemes, and, as in the 1960s, most ended when their leaders left. Arie's department in Nottingham closed soon after his retirement in 1995.²⁰ However, by that time there were probably new organisational influences upon joint working. Geriatrician Jacqueline Morris described the demise of her P-GAU, based on Arie's model, in west London in the early 1980s. Her unit did not end when she left, but, as she reflected in 2010: 'Sadly, the benefits of collaboration were seen to be secondary to the development of the larger departments of medicine and mental health'.²¹ Rather than promoting ideals of creating a holistic approach to older people's health, the expansion of both psychiatry and geriatrics, each with

¹⁵ Pitt and Silver, 'Combined approach'

¹⁶ GPOA, minutes, 17.5.1973, 2.c. (RCPsychA); Langley, 'Exe Vale' 127

¹⁷ Tom Arie, Tom Dunn, 'A "do-it-yourself" psychiatric-geriatrics joint patient unit' *Lancet* (1973) ii: 1313-1316

¹⁸ Arie, 'Witness' 29

¹⁹ Arie and Murphy, 'A conversation' 678; Arie, interview by author (2004)

²⁰ Arie and Murphy, 'A conversation' 671

²¹ Jacqueline Morris, 'Old age physicians and psychiatrists: past, present and future collaboration' *OAP* (2011) 53: 21-22 22

different clinical skills, objectives, training and recruitment issues, seemed to perpetuate a division.

Planning services

The Organisation of Psychogeriatrics,²² a joint geriatric-psychiatric report in 1970, was instrumental in the BGS approaching the RCPsych to establish a joint working party in 1972.²³ This BGS/RCPsych group aimed to promote clinical collaboration and provision of old age services for physical and mental disorders.²⁴ An initial series of meetings produced recommendations endorsed by both organisations.²⁵

After a gap in BGS/RCPsych meetings, in 1975, the BGS and DHSS together produced a critical report on how psychogeriatrics should be organised, only afterwards requesting consultation with psychogeriatricians.²⁶ This report was received by the GPOA ‘with considerable interest’ and some perplexity, and probably led to reconvening the BGS/RCPsych working party.²⁷

The BGS/RCPsych working party in 1979 updated guidelines for collaborative working.²⁸ A draft was sent to the DHSS,²⁹ although it is unclear whether or how they responded. The guidelines emphasised important principles, including that geriatric and psychogeriatric services should be ‘a unity for “consumers”’; responsibility for treatment ‘should be determined by the assessed needs of the patient’ and not by ‘quirks of referral’ or availability of resources; ‘No-one should be labelled as “a psychiatric patient” by virtue

²² Page 239; Enoch and Howells, *Organisation*

²³ BGS/RCPsych, ‘Joint report’ (1973) 2-3; BGS/RCPsych, meeting, 22.6.1972 (TA)

²⁴ BGS, ‘Psycho-geriatrics’ (c.1971) (TA)

²⁵ BGS/RCPsych, ‘Joint report’ (1973)

²⁶ BGS, ‘Preliminary report of the working group on mental health in old age’; with letter from DHSS to Pitt, 27.1.1975 (PJ)

²⁷ GPOA, minutes, 30.10.1975, 4.c. (RCPsychA)

²⁸ Anon. ‘Guidelines for collaboration between geriatric physicians and psychiatrists in the care of the elderly’ *Psychiatric Bulletin* (1979) 3: 168-169

²⁹ BGS/RCPsych, ‘Guidelines for collaboration between geriatric physicians and psychiatrists in the care of the elderly’ Jan. 1978; Arie to Miss Cobbing (secretary of RCPsych) letter, 20.4.1978 (PJ)

merely of some previous psychiatric episode'.³⁰ The guidelines influenced practice for decades.³¹ The working party also aimed to improve staff communication and education³² and training for doctors in each other's specialty.³³

Although generally there was a mutually supportive working relationship between geriatricians and psychogeriatricians in planning services,³⁴ some initiatives shifted between geriatrics and psychogeriatrics rather than being tackled jointly. For example, the first memory clinic in 1983 was geriatrics-led, at University College Hospital, London,³⁵ in the department established by Amulree, but later memory clinics were typically part of psychogeriatric services.³⁶

Implications for recognition of the specialty of psychogeriatrics

Understanding the organisation of geriatric medicine helps contextualise the process of psychogeriatrics being recognised as a separate specialty.

Despite similarities, the two specialties differed in important ways. Thus lessons learnt by the DHSS from one might not apply to the other. For example, whereas some physically unwell older patients required referral to specialists other than geriatricians, such as cardiologists, gastroenterologists or surgeons, psychogeriatricians aimed to accept all newly referred psychiatric patients above a specified age. However, the Royal College of Physicians' (RCP)

³⁰ Anon. 'Guidelines for collaboration'

³¹ BGS/RCPsych, 'Guidelines for collaboration between physicians of geriatric medicine and psychiatrists of old age' (2007) http://www.bgs.org.uk/index.php?option=com_content&view=article&id=361:geriatricianpsychiatristcollaboration&catid=12:goodpractice&Itemid=106 accessed 30.4.2013

³² BGS/RCPsych/RCN/HAS conference, 'The quality of life in extended care wards' 11.3.1982 (RCNA, RCN/15/7/1/14)

³³ SPOA, 'A memorandum - training in old age psychiatry for senior registrars in geriatric medicine and training in geriatric medicine for senior registrars in old age psychiatry' (c.1980) (RCPsychA)

³⁴ e.g. BGS/RCPsych liaison group, minutes, 12th meeting, 4.7.1982; 27th meeting 23.11.1989 (RCPsychA)

³⁵ Tischa Van der Cammen *et al.* 'The memory clinic' *BJPsych* (1987) 150: 359-364 364

³⁶ Jane Foy, 'A survey of memory clinic practice in Scotland' *Psychiatric Bulletin* (2008) 32: 467-469

suggestion in 1977 concerning under-provision of dedicated services for geriatric medicine applied equally to both. Both required

fundamental changes in society's attitude to old people ... [and] provision of the necessary conditions and resources to enable the work to be done well, and so to attract more of the ablest doctors into this field.³⁷

Discussions about reintegrating geriatrics into general medicine, recommended by the RCP in 1977, may have contributed to pushing psychogeriatrics and geriatrics apart³⁸ and were perhaps related to the ending of Arie's and Morris's joint units. Various reasons were given for geriatric reintegration,³⁹ but most related to difficulties of recruitment to the specialty: 'bringing geriatrics into the main stream of medicine' might help in 'attracting to the specialty the talent it needs and deserves',⁴⁰ implying physicians' lack of interest in working solely with older people. Suggestions for reintegrating geriatrics had the potential to undermine enthusiasm at the DHSS and the RCPsych for recognising psychogeriatrics as a separate specialty in case a similar debate followed. Although an internal DHSS memo discussing reintegration of geriatric medicine was attached to papers concerning developing psychogeriatric services,⁴¹ definite conclusions cannot be inferred from this since internal civil service memos mention many ideas but their significance in decision making is variable.

Geriatricians shared with psychogeriatricians the experience of fighting for the existence of their specialty. In 1984 a debate at the RCP proposed: 'The care of the elderly is harmed by the specialty of geriatrics', contending that general physicians were as good as specialist geriatricians at looking after older people.⁴² This is reminiscent of the complex relationship between general

³⁷ RCP, 'Medical Care of the Elderly' *Lancet* (1977) i: 1092-1095 1092

³⁸ RCP, 'Medical care of the elderly' 1094; J Grimley Evans, 'Integration of geriatric with general medical services in Newcastle' *Lancet* (1983) i: 1430-1433; Pitt, 'Witness' 28

³⁹ Evans, 'Integration' 1433

⁴⁰ Anon. 'How to rescue geriatrics' *Lancet* (1977) i: 1091

⁴¹ DHSS internal memo, signature illegible, 11.3.1980 (TNA, MH 154/1328)

⁴² Anon. 'Care of the elderly: is it a specialty?' *Lancet* (1985) ii: 459

psychiatrists and psychogeriatricians.⁴³ The same year, the NPHT commissioned Sir Ivor Batchelor, professor of psychiatry at Dundee, to write a critique of DHSS policies for old age. He included comments on the low professional status of geriatric medicine despite its clinical success; its ‘undistinguished’ contribution to research; the need for ‘a more talented intake into the training grades’.⁴⁴ He criticised the professional group but not their clinical achievement, which is strange, considering that clinical work is the *raison d'être* for the profession. His comment on geriatric research may have had a similar basis to that of editors of prestigious general medical journals rejecting papers on old age subjects – because of the subject matter rather than on grounds of scientific rigour. That happened to some psychogeriatric research from Newcastle.⁴⁵ His criticisms may have contained an element of truth, but they perhaps also reflected a broader lack of professional interest in older frail patients or, in Batchelor’s words, the ‘snobbery of physicians, who have viewed the geriatrician as more often than not a failed physician or at best a physician manqué’.⁴⁶

Batchelor wrote more favourably on psychogeriatrics:

Its practitioners have got off to a good start ... initiatives have come largely from the profession itself ... Psychogeriatrics, which has its own ‘head of steam’ as a specialty, will be best left to develop in its professional context without much Departmental urging.⁴⁷

This positive stance might have been biased by his personal interest as a psychiatrist, although he rebutted that possibility.⁴⁸ However, his praise did not correspond with his barely lukewarm conclusions: DHSS support for geriatrics and psychogeriatrics should enable them to ‘lead, innovate, develop, and research into the services necessary, and establish and teach exemplary high

⁴³ Pitt, interview by author (2006); Pitt, ‘Witness’ 18

⁴⁴ Ivor Batchelor, *Policies for a crisis? Some aspects of the DHSS policies for the care of the aged: a commentary* (London: NPHT, 1984) 46-47

⁴⁵ Garry Blessed, letter, 7.6.2013

⁴⁶ Batchelor, *Policies for a crisis?* 47

⁴⁷ *Ibid.* 47

⁴⁸ *Ibid.* 2

standards of caring and treatment’ without providing comprehensive services.⁴⁹ This was unrealistic. As in all clinical specialties, excellent clinical teaching could only be achieved by allowing students and junior staff to experience high quality practice, not as an alternative to it.

Batchelor’s ambivalence resembled the view of the Royal Commission on the NHS in 1979, that old age work was not an ‘attractive category’ for full-time clinical specialisation.⁵⁰ It is difficult to identify direct effects of Batchelor’s report on the old age specialties, but it was unlikely to motivate the DHSS to recognise psychogeriatrics or support geriatric medicine. In 1989, professor of geriatrics Peter Millard and his colleagues at St George’s Hospital Medical School, London, were sufficiently concerned to allege that the government was ‘now destroying’ their specialty.⁵¹

Another medical specialty: general practice

Collaboration between GPs and psychogeriatric services was vital to allow referral of patients for specialist attention and to facilitate community care.

Until the 1980s, little was written specifically about old age mental illness from the primary care perspective. For GPs, people over 75 comprised about 7% of their patient encounters.⁵² Of that age group, probably around 30% would have had a psychiatric disorder of any sort, so GPs had limited relevant experience. Some research suggested that GPs lacked interest in working with older people.⁵³ Mental illness was sometimes omitted from guidelines on good practice, such as the Royal College of General Practitioners’ *Preventive Care of the Elderly* in 1987,⁵⁴ suggesting lack of concern or lack of knowledge.

⁴⁹ *Ibid.* 48

⁵⁰ *Report of the Royal Commission on the NHS*, 64

⁵¹ Peter Millard, P Higgs, P Rochon, ‘Aging: should it be left to chance?’ *BMJ* (1989) 298: 1020-1021 1020

⁵² Helen Graham, ‘MRCGP candidates and the elderly’ *JRCGP* (1987) 37: 85

⁵³ M Keith Thompson, ‘Care of the elderly’ *JRCGP* (1987) 37: 133

⁵⁴ Rex Taylor, Graham Buckley, (ed.) ‘Preventive Care of the Elderly: a review of current developments’ *JRCGP* (OP) (1987) 35: 1-53

One study, in the *Journal of the Royal College of General Practitioners (JRCGP)* in 1986, specifically evaluated mental function in old age in primary care. It was researched, unsurprisingly, in Newcastle upon Tyne,⁵⁵ which had university departments of both geriatrics and psychogeriatrics. This reinforced the observation that personal links and local inspiration might encourage interest in unpopular fields. Wattis, in 1988, called it a 'ripple effect'.⁵⁶ Initiating enthusiasm elsewhere was harder.

Research published in the *JRCGP* indicated discrepancies in rates of detecting and treating mental and physical illness in older people in primary care and gave clues about attitudes towards their health. One paper about consultation rates of older people mentioned mental illness only in the context of excluding potential participants who were too confused or too depressed to be interviewed, without further definition.⁵⁷ Such exclusions could lead to inaccuracies in determining consultation rates and patients' needs. In particular, confused or forgetful people might be unable to express their needs or seek help and depressed people might consult more if worried about their health, or less if they believed they had little hope of recovery. Older people, often with depression, were more likely than any other age group to commit suicide,⁵⁸ making it even more disquieting when primary care research studies of depressive illness excluded people over 65.⁵⁹ Disconcertingly, one community study found that only 14% of older people diagnosed with depression received antidepressant treatment,⁶⁰ and relatively few were referred for specialist psychiatric advice.⁶¹

⁵⁵ S Jachuck, S Stobo, A Sahgal, 'Evaluation of the mental function of the elderly in a general practice' *JRCGP* (1986) 36: 123-124

⁵⁶ Wattis, 'Geographical variations' 179

⁵⁷ Graeme Ford, Rex Taylor, 'The elderly as underconsulters: a critical reappraisal' *JRCGP* (1985) 35: 244-247 245. Too frail or too deaf were other exclusions.

⁵⁸ James Lindesay, Elaine Murphy, 'Suicide in old age' *IJGP* (1987) 2: 71-72 71

⁵⁹ R Burton, P Freeling, 'Unrecognized depression in general practice' *JRCGP* (OP) (1987) 36: 12-16 14

⁶⁰ John Copeland, 'Prevalence of depressive illness in the elderly community' *JRCGP* (OP) (1987) 36: 5-8 8

⁶¹ Alastair MacDonald, 'Do general practitioners "miss" depression in elderly patients?' *BMJ* (1986) 292: 1365-1367 1367

Various factors could affect clinical management in primary care. For mental difficulties, older people or their families might not seek advice from their GPs, perceiving the problems as an inevitable part of ageing or inhibited by the fear and stigma of mental illness or psychiatric hospitals. There was also some evidence that older people with any illness were under-diagnosed: one study found that GPs do 'less investigative work with elderly patients and the level of referral to consultants is the same for patients of all ages'.⁶² Since more pathology occurs in old age, less investigation and no increase in referrals to specialists suggests a mindset among GPs and patients about the inevitability of impairment, despite evidence of benefit from active intervention.⁶³ GPs were more likely to refer older people to district nursing and social services,⁶⁴ suggesting that they were regarded as best suited to passive care rather than active treatment.

Occasionally, GPs mentioned advantages of having psychogeriatric services 'closely allied' to primary health care teams, but psychogeriatrics was sometimes almost synonymous with shortage of resources.⁶⁵ Where specific psychogeriatric services existed, GP referral rates increased disproportionately: at Crichton Royal, between 1974 and 1984, a 16% increase in population over 65 was associated with a 150% increase in referrals mainly from primary care,⁶⁶ suggesting that GPs valued the interventions provided. In localities without dedicated psychogeriatricians, doubt about the relative responsibilities of hesitant hospital colleagues, both geriatricians and psychiatrists, and lack of easily accessible useful advice, treatment or clinical support could have affected GPs' enthusiasm for identifying disorders. There was little point in doing so if GPs believed that nothing could, or would, be achieved.

⁶² David Wilkin, E Idris Williams, 'Patterns of care for the elderly in general practice' *JRCGP* (1986) 36: 567-570 567

⁶³ Anon. 'Caring for the Aged' *BMJ* (1981) 282: 1817-1818 1817

⁶⁴ Wilkin and Williams, 'Patterns of care' 567

⁶⁵ H Humphreys, 'Care in the community' *JRCGP* (1984) 34: 361-363 361

⁶⁶ Alex Christie, Eric Wood, 'Psychogeriatrics 1974-1984: expanding problems and fixed resources' *BJPsych* (1987) 151: 813-817 814-815

Empathic interactions: social workers, nurses and psychologists

Social work and nursing, well established within clinical multi-disciplinary psychogeriatric team work, and psychology, a recent addition to it, influenced the style and quantity of service provision only indirectly. From the 1970s, there was constructive multi-disciplinary participation, such as in *The Rising Tide* initiative, and more suggestions as to how these disciplines might contribute to future developments.

Social workers

While psychogeriatrics was emerging as a distinctive specialty, social work was becoming more generic as a result of Seebohm's reforms (1968). Hospital social workers with experience of working with older people moved into generic local area teams. Their expertise was diluted when their responsibilities changed to include all age groups. This was unlikely to encourage them to be involved in psychogeriatric work, research or service development. Social workers interested specifically in older people voiced frustration:

The generic social worker and the generic social work team, I dare say, number some elderly people amongst their clients or patients. There cannot be many of us who have dealings with services for the elderly who are not frustrated and exasperated by the piecemeal and variable services the Country over ... [with] little or no opportunity to ... put up ideas, or participate in improving the service.⁶⁷

From the HAS perspective, Woodford-Williams commented: 'The weakening of links with social services ... is keenly felt by consultant geriatricians and psychiatrists'.⁶⁸ The RCPsych requested reintegration of mental health social workers from the local authority area teams back into the health service, but to no avail.⁶⁹

⁶⁷ J Kenyon Rogers, 'Service for the elderly: a special interest group' *SWT* 1.11.1973, BASW News, 4.15 470

⁶⁸ Eluned Woodford-Williams, 'Foreword'. In: NHS, *Annual Report HAS*

⁶⁹ RCPsych, 'Memorandum on the National Health Service Reorganisation consultative document' *BJPsych* Supplement (Dec. 1971) 2-3

There was no clear body of theoretical knowledge within social work to guide policy or measure success,⁷⁰ especially for older people's care. As in the 1960s, social work academic journals published little on older people compared with numerous articles on children and other vulnerable groups. A lengthy paper in the *British Journal of Social Work (BJSW)* in 1973 on poverty, for example, hardly referred to older people.⁷¹ As with government planning, not mentioning older people did not necessarily exclude them, but left ambiguities rather than a sense of interest, direction and responsibility for provision. It conveyed that their particular needs were unimportant and discouraged the development of specific skills and services, contrary to evidence of benefit from dedicated psychogeriatric practice.

One social worker, writing in the *BJSW* in 1977, took a surprisingly outdated standpoint:

The concept of psycho-geriatric illness is not universally accepted. Some argue that social factors induce regression; others see it as another aspect of the natural ageing process.⁷²

There was ample evidence, widely accepted in geriatric and psychogeriatric practice, for the biological nature of 'psycho-geriatric illness'. Rejecting the illness model might discourage collaboration with psychogeriatricians who could improve mental wellbeing and thus optimise the use of social care resources. Varying understanding and attitudes probably contributed to sometimes less than ideal multi-agency and inter-specialty relationships.

A geriatric special interest group of the British Association of Social Workers (BASW)⁷³ requested education on psychogeriatrics in 1977.⁷⁴ The same year, ideas were shared between psychogeriatricians and social workers when the

⁷⁰ Lowe, *Welfare State*, 263

⁷¹ Robert Holman, 'Poverty: consensus and alternatives' *BJSW* (1973) 3: 431-446

⁷² Mary Green, 'Aspects of old age' *BJSW* (1977) 7: 301-320 307

⁷³ Anon. 'BASW geriatric special interest group' *SWT* 18.10.1973, *BASW News*, 4.14 436

⁷⁴ GPOA, minutes, 23.6.1977, 40/77 (RCPsychA)

GPOA invited social work leaders to address them⁷⁵ and a multi-disciplinary, multi-agency conference on psychogeriatric services was held.⁷⁶ Such bridge building was essential, to overcome the perennial problems encountered in supporting mentally ill older people. As Arie commented about dementia, 'No other condition generates so much crisis, irritability, and inter-professional friction'.⁷⁷

There are suggestions that some social workers were becoming more involved in the field. Mary Marshall, a social worker by training, worked with older people during the 1980s. In 1989, she was appointed director of the Dementia Services Development Centre (the first of its kind in the UK) in Stirling, Scotland. This gave her a lead role in developing UK dementia services.⁷⁸ Her focus of work thus moved from old age generally to dementia care specifically. Other social work leaders around that time, such as Jill Manthorpe and David Challis, were also beginning to take more interest in older people's mental illness.

Nurses

A Handbook for Psychiatric Nurses in 1971 included stereotypical inaccuracies about decline in old age, which could affect attitudes and provision of care. It stated 'And as their memory fails',⁷⁹ erroneously implying that declining memory was inevitable, which could reinforce the futility of rehabilitative approaches. It re-stated the classical Greek theory, unsupported by modern research, that 'as the body dries up and the subcutaneous fat disappears, the skin becomes dry and wrinkled'.⁸⁰ The body does not dry up, but perhaps the disappearance of subcutaneous fat, at least in part, was associated with

⁷⁵ *Ibid.* 51/77

⁷⁶ Colin Godber, 'Conference with DHSS on future psychogeriatric services: revised proposals' 27.10.1975; Conference programme, 'Our elderly' July 1977 (PJ)

⁷⁷ Arie, 'Diagnosis and assessment' 540

⁷⁸ Elaine Murphy, 'Mary Marshall OBE: an appreciation' 6-8. In: *Mary Marshall: an e-festschrift*. PSSRU, University of Manchester (2005)
<http://www.nursing.manchester.ac.uk/pssru/research/nwdc/news/marymarshall.pdf> accessed 7.1.14 7

⁷⁹ Tecwyn Roberts, *A Handbook for Psychiatric Nurses* (Bristol: John Wright, 1971) 19

⁸⁰ *Ibid.* 19

inadequate diet related to poverty or poor care in long-stay hospitals. Indeed, the *maximum* to be spent on food in psychiatric hospitals was £2.06p a week, 6p a week less than the *minimum* in acute hospitals.⁸¹

Altschul and Simpson's textbook *Psychiatric Nursing* (1977) included a chapter on 'old people'. It was generally upbeat and advocated rehabilitation, maintaining the patient's independence and sense of personal identity.⁸² Occasionally it appeared to promote institutionalisation, such as advising that the nurse could 'exploit the phase when the patient accepts dependence, use it to build up prestige and will be grateful for the patient's non-critical submission to treatment'.⁸³ Given recent developments in psychogeriatrics aiming at broadly improving quality of life in dementia, it also took a surprisingly narrow view of dementia nursing, 'concerned primarily with the preservation of physical health'.⁸⁴ In the context of inadequate staffing levels, authoritarian and mechanistic nursing may have been considered the only option, but it risked placing nurses' needs above those of patients.⁸⁵ By disregarding the individuality of patients, nursing practice might inadvertently have made their abuse more likely.

Stereotypical assumptions by nurses about older people, a mechanistic view of psychogeriatric nursing, low morale and staff shortages on many psychogeriatric wards which were regarded as low status by nurses, and the traditional hierarchical nurse-doctor working relationship, probably all contributed to the lack of nurse leadership for creating and improving psychogeriatric services. Nevertheless, there were some initiatives to improve the situation. Community psychogeriatric nursing – treating patients in their own homes – was encouraged by the HAS.⁸⁶ Psychogeriatric nursing practices

⁸¹ KJ Moyes (DHSS) to RHBs, 22.3.1972, letter concerning: DHSS, 'Schedule of minimum standards in hospitals for the mentally ill' DS86/72 (1972) 23-24 (TA)

⁸² Annie Altschul, Ruth Simpson, *Psychiatric Nursing* (London: Baillière Tindall, 1977) 150-164

⁸³ *Ibid.* 151-152

⁸⁴ *Ibid.* 324

⁸⁵ Brooks, "The geriatric hospital felt like a backwater" 2768

⁸⁶ NHS, *Annual Report HAS*, 31

backed by sound principles were emerging, but they were not yet commonplace in daily work or in training.⁸⁷ In 1976, a new multi-disciplinary text-book advocated widening the range of skills taught during nurse training to include community and rehabilitation approaches for older people.⁸⁸ In 1978, the GPOA, concerned about nursing shortages and the ‘serious lack of central guidance’ to remedy it,⁸⁹ sought more dialogue with nursing leaders and invited the DHSS nursing advisor to meet them⁹⁰ although no details about the meeting were found. Other attempts were made to generate interest in psychogeriatric nursing, such as by including it at a Royal College of Nursing geriatric long-term care conference in 1978.⁹¹ Despite positive steps, a lecturer at a nursing conference in 1982, commented: ‘the thought of being permanently posted to a psychogeriatric ward fills newly qualified nurses with dread’.⁹²

Disheartening attitudes within the profession did not discourage nurse Sue Hadden:

In 1985 I chose to work ... on a ward that had inspired me during my training. Senior staff were perplexed that I wanted ‘psychogeriatrics’ ... such a derogatory label. Yet it was clear to me that on the ward we had the chance to truly assess all aspects of a person, holistic care in action rather than in a textbook.⁹³

Maggie Lee, an occupational therapist, had comparable recollections about her experiences in the 1980s:

My first ever role as an occupational therapy assistant was in a ‘long-stay’ unit ... It set a standard I have yet to see replicated. ...

⁸⁷ Clarke, M. ‘Organising nursing services’ 108-110. In: *Brain Failure in Old Age: proceedings of a conference held in December 1975 in Jersey, Channel Islands* ed. William Ferguson Anderson, JR Carlton-Ashton *Age Ageing* (1977) Supplement, 110

⁸⁸ Alex Baker, Mollie Clark, ‘Mental illness in the elderly’ 270-287. In: *Comprehensive Psychiatric Care* ed. Alex Baker (Oxford: Blackwell Scientific Publications, 1976) 281-287

⁸⁹ GPOA, ‘Nurse staffing’ 4

⁹⁰ GPOA, minutes, 20.4.1978, 29/78 (RCPsychA)

⁹¹ G Kiss, ‘Psychogeriatric patients – long-stay’ RCN Society of Geriatric Nursing, ‘Long term caring – the welfare of nurse and patient’ Sept. 1978 (RCNA, RCN/15/7/2/8)

⁹² R Macrowan, ‘To nurse or not to nurse?’ 18-19. In: ‘The quality of life in extended care wards’ Conference proceedings, 11.3.1982, 18 (RCNA, RCN/15/7/1/14)

⁹³ Sue Hadden, ‘The essence of our care: a nursing perspective’ *OAP* (2011) 53: 24-25 24

A lecturer on a recent course [c.2010] stated that if you wanted a career as an occupational therapist in the '80s, you didn't work with older people.⁹⁴

Hadden's and Lee's experiences of psychogeriatric work contrasted with the negative perspectives of managers and teachers which risked discouraging recruitment. Negative stereotypes probably reflected lack of understanding of the assessments and interventions offered in modern psychogeriatrics, and influenced the General Nursing Council's decision in 1983 not to recognise nursing on acute psychogeriatric assessment wards as suitable experience for training.⁹⁵ By 1987, psychogeriatrics was still not routinely included in nurse training.⁹⁶ Lee's comments also suggest reasons why occupational therapy is hardly mentioned in this thesis: the low status of old age work rarely attracted enthusiastic, inspired leaders into the field.

Psychology

Including psychologists within the psychogeriatric multi-disciplinary team was extremely unusual before the 1980s. Their role in developing and using tools to assess cognitive function was well recognised,⁹⁷ although their use of psychotherapeutic techniques in old age was not, partly due to Freud's nihilistic attitude towards learning by older people.⁹⁸ Nevertheless, new psychologically based approaches, such as reminiscence, validation and reality orientation, were adopted by clinical teams.⁹⁹ These methods were reported to help patients while enabling staff to get to know them as people, encouraging positive attitudes.¹⁰⁰

⁹⁴ Maggie Lee, 'And what about occupational therapy?!' *OAP* (2011) 53: 26-27 26

⁹⁵ Rodney Wilkins, 'Summary' 5-6. In: 'Quality of life' 6 (RCNA, RCN/15/7/1/14); SPOA, minutes, 1.12.1983, 39/SPOA83 (RCPsychA)

⁹⁶ RCP/RCPsych, 'Joint working party on the care of the elderly mentally ill' 14.7.1987, 4.a. (RCP, MS4811)

⁹⁷ Robert Mapou, 'Introduction' 1-13. In: *Clinical Neuropsychological Assessment: a cognitive approach* ed. Robert Mapou, Jack Spector (New York: Plenum Press, 1995) 1-2

⁹⁸ Freud, 'On psychotherapy', 264

⁹⁹ JC Folsom, 'Reality orientation for the elderly mental patient' *Journal of Geriatric Psychiatry* (1968) 1: 291-307; Naomi Feil, *Validation: the Feil method* (Cleveland, OH: Edward Feil Productions, 1982)

¹⁰⁰ S Baines *et al.* 'Reality orientation and reminiscence therapy: a controlled cross-over study of elderly confused people' *BJPsych* (1987) 151: 222-231 229

In 1985 a conference was organised to facilitate psychologists and psychiatrists working together across the entire lifespan. Its title, 'Psychiatrists and psychologists: co-operation or confrontation?' revealed tensions in clinical practice between the disciplines.¹⁰¹ An example of the tensions in clinical practice with older people in the late 1980s is indicated by a psychologist recalling, in an interview, her shock at hearing a psychogeriatrician referring to long stay 'dements' being put in 'storage'.¹⁰² Precisely how that term was being used was unclear. It was also used provocatively in parliament.¹⁰³ Such terminology risked angering not just psychologists but many multi-disciplinary team members, including psychogeriatricians.¹⁰⁴ In psychogeriatric units with a less holistic approach, psychologists identified roles for themselves to increase individually focussed approaches to care. These included planning therapeutic interventions for patients, supporting carers and assisting with training of staff on long-stay wards.¹⁰⁵

The British Psychological Society's Psychology Special Interest Group in the Elderly (PSIGE) was inaugurated in 1980. It aimed to establish psychology's unique contribution to the wellbeing of older people.¹⁰⁶ Early PSIGE newsletters revealed the paucity of old age posts for psychologists, as well as the impossibly high workload expected in them, such as working on two sites 'with two consultant psychogeriatricians ... [to] provide an input at both centres as well as developing work in the Primary Care Field'.¹⁰⁷ These appeared tokenistic rather than realistic, reminiscent of the appointment of some consultant psychogeriatricians to impossible posts.¹⁰⁸ High workloads

¹⁰¹ Jim Birley, 'Psychiatrists and psychologists: co-operation or confrontation?' *Psychiatric Bulletin* (1985) 9: 123-125

¹⁰² Turner, interview by author (2010)

¹⁰³ Gwynneth Dunwoody, HC Deb 24.8.1988

¹⁰⁴ Mary Marshall, 'A social worker's perspective' *OAP* (2011) 53: 28

¹⁰⁵ Turner, interview by author (2010); Horrocks, 'Components' 336

¹⁰⁶ Una Holden, Chairman's letter, *PSIGE Newsletter* (1982) 5: In PSIGE newsletters pages are generally un-numbered.

¹⁰⁷ *PSIGE Newsletter* (1981/82) 4:

¹⁰⁸ Brook, 'Assessors' reports' 9

and lack of enthusiasm for the specialty led to suggestions of paying enhanced salaries, as for other posts which had proved unattractive, such as in geriatric and psychiatric nursing. For old age psychology, it was rejected, to avoid new staff taking up posts for the salary rather than genuine interest.¹⁰⁹

In 1985 there were still only 24 full time specialist old age psychologists in the UK.¹¹⁰ The need to establish their professional identity and roles was their priority. The SPOA and PSIGE collaborated through closer working, sharing of ideas and encouraging PSIGE to promote a clearer understanding of what psychologists could offer.¹¹¹ Some psychologists, such as Chris Gilleard,¹¹² took a lead in psychogeriatric research which had the potential to influence wider practice.

As with the psychogeriatricians, old age psychologists started with a small nucleus of enthusiasts, only gradually conveying their interest to others. They too needed to dispel ‘myths within our profession which had led to therapeutic nihilism regarding elderly clients’.¹¹³ It is unclear how much the slow development of old age psychology services was solely a phenomenon of creating a new specialty,¹¹⁴ or if it related to stereotypic therapeutic nihilism or beliefs that psychology specifically for older people was unnecessary as their needs were no different from those of younger people.¹¹⁵

International relations: UK leadership and creating a journal

Psychogeriatric research in the UK during the 1960s and 1970s was regarded by Canadian psychogeriatrician Kenneth Shulman as ‘well ahead of the North

¹⁰⁹ Barry Gatreux, ‘Ageism and the professional psychologist’ *PSIGE Newsletter* (1982) 5:

¹¹⁰ Birley, ‘Psychiatrists and psychologists’ 125

¹¹¹ Anon. ‘Report of meeting with RCPsych’ *PSIGE Newsletter* (1987) 24: 18

¹¹² Chris Gilleard, *Living with Dementia: community care of the elderly mentally infirm* (London: Croom Helm, 1984)

¹¹³ Jeff Garland, ‘Knowing where to start: establishing a service for the elderly’ *PSIGE Newsletter* (1982) 6:

¹¹⁴ Rosen, *Specialisation*

¹¹⁵ Jeff Garland, ‘Some distinguishing features of psychological practice with older people’ *PSIGE Newsletter* (1988) 27: 3-7

American scene'.¹¹⁶ In 1972, Roth and Kay contributed to the report by WHO, *Psychogeriatrics*. Interestingly, the title followed the UK convention rather than the North American 'geriatric psychiatry'. Roth and Kay's ideas appeared to shape the report significantly, or perhaps other contributors already shared their views. Precisely which is unclear, because the report lacked references.

International comparisons of clinical practices and service provision were difficult, although that lessened in the 1970s with improved diagnostic definitions and standardised clinical research methodology. A US-UK study in the early 1970s in which patients over 65 were investigated (possibly as an afterthought following a study on patients age 19-59) confirmed similar rates of old age organic and functional illnesses in both countries.¹¹⁷ The study also resulted in a validated, standardised research interview for diagnosing mental illnesses in old age, an important and necessary achievement, since existing tools were less suitable for this age group.¹¹⁸ Nevertheless, international comparisons about the effectiveness of different styles of service provision remained difficult. For example, compared to England, the USA had no national psychiatric hospital data and individual psychiatric hospitals were difficult to compare as catchment area populations and availability of community and other hospital resources differed. Psychiatrists in the USA normally used American rather than WHO diagnostic criteria, did more private psychiatry, psychoanalysis and work with often relatively mentally healthy people¹¹⁹ compared with the biological approach towards generally sicker people in the NHS. In addition, in the USA, old age integrated health care was difficult to implement, partly because of lack of underlying welfare structures and the funding regulations of the government's health insurance program for

¹¹⁶ Shulman, 'Future of geriatric psychiatry'

¹¹⁷ John Copeland *et al.* 'Cross-National study of diagnosis of the mental disorders: a comparison of the diagnoses of elderly psychiatric patients admitted to mental hospitals serving Queens County, New York, and the former Borough of Camberwell, London' *BJPsych* (1975) 126: 11-20 11

¹¹⁸ John Copeland *et al.* 'A semi-structured clinical interview for the assessment of diagnosis and mental state in the elderly: the Geriatric Mental State Schedule 1. Development and reliability' *Psychological Medicine* (1976) 6: 439-449

¹¹⁹ Shorter, *History of Psychiatry*, 293-295

older people.¹²⁰ By contrast, the UK model of psychogeriatrics and geriatrics, linking primary care, acute hospital treatment, community and long-term care, based on research and facilitated by the structure of the welfare state, was internationally regarded as effective and appropriate for treating and supporting older people.¹²¹

In Europe, services in different countries were at various stages of development. English language descriptions of the range of services available were difficult to find, for example, in WHO literature or in high-ranking journals such as *Acta Psychiatrica Scandinavica* which took a broad international approach. Descriptions in other languages were not sought. Notably, in the mid-1980s, the SPOA had successful joint conferences with Dutch psychogeriatricians.¹²²

The Czech Psychogeriatric Association was founded in 1968, but, with reduced international contact after the Russian occupation in the same year, there was little development of services. In the Czech Republic in 1995:

psychiatrists' interest in old age psychiatry is still very low, and the rapid privatisation of health that has occurred since the revolution in 1989 has if anything made matters worse.¹²³

In France, by 1992,

services are still based on institutional care and any change or project comes up against the weight of the institution. Another characteristic of French public psychiatry is the little interest it takes in the subject of aging.¹²⁴

¹²⁰ William Barker, 'Hospital based geriatric services in Great Britain: implications for the US' (1983) 38, 40 (BGSA)

¹²¹ e.g. Barker, 'Implications for the US' (BGSA); Helen Chiu, 'A view from Hong Kong' *OAP* (2011) 53: 38

¹²² SPOA, minutes, 31.5.1984, 16SPOA/84; 23.5.1985, 18EC/85 (RCPsychA)

¹²³ Miloš Vojtechovský, 'The development of old age psychiatry in the Czech Republic' *Human Psychopharmacology: Clinical and Experimental* (1995) 10: Supplement 4: S213-S218

¹²⁴ S Maltaverne, 'Local experiences in French psychogeriatrics' 36-42. In: WHO, *Mental Health and Aging: report on an informal consultation* (Geneva: WHO, 1993) 37

In Belgium, similar to the UK, provision for rehabilitation and chronic disorders competed with high-tech services. By the 1990s, dedicated psychogeriatric services were lacking; community psychiatric teams usually worked with adults of all ages and younger patients received priority.¹²⁵

Reviewing the contents pages of the *International Journal of Geriatric Psychiatry* as an indicator of interest in the late 1980s, most reports about community-based services were by UK authors, with some papers from other countries such as Australia, Canada, Israel, Japan and the USA. By contrast, most European studies focussed on institutionalised patients or the scientific basis of psychiatric disorders in old age. International surveys in the 1980s, specifically about psychogeriatric services, were lacking. An international survey in 1997 reported that the UK, Netherlands and Switzerland had the best developed psychogeriatric services and that the profession of psychogeriatrics was best developed in the UK, USA and Finland.¹²⁶

Given the wide respect for UK psychogeriatrics and an international lack of trained psychogeriatricians in the 1980s,¹²⁷ the British Council, the UK's international cultural relations body, sponsored psychogeriatric courses for a decade. They were organised by Arie in Nottingham for participants from over 30 countries and were taught by an eminent multi-disciplinary team. 'Arie Courses' (Fig 19) also took place in Australia, Israel, Poland and Portugal.¹²⁸ These courses had a significant long-term impact, for example in Australia, giving 'old age psychiatry its start when there was no specific training programme Down Under'.¹²⁹

¹²⁵ Daniel Brand, Jean Nicaise, 'Psychogeriatrics in Belgium: a brief overview' *Human Psychopharmacology: Clinical and Experimental* (1995) 10: Supplement 4: S219–S222 S220, S221

¹²⁶ Burton Reifler, Wayne Cohen, 'Practice of geriatric psychiatry and mental health services for the elderly: results of an international survey' *International Psychogeriatrics* (1998) 10: 351–357 354, 355

¹²⁷ Birley, 'Smell of success' 131

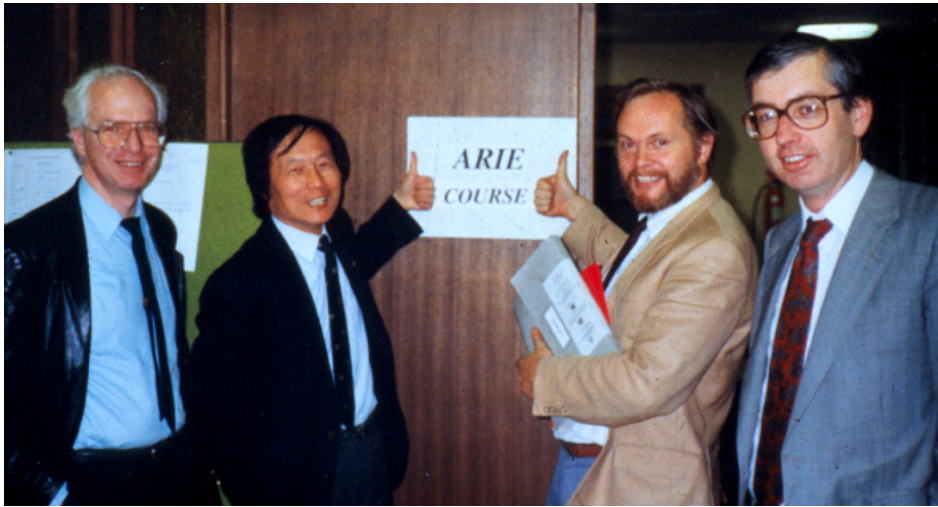
¹²⁸ Arie, 'The development in Britain' 9

¹²⁹ Edmond Chiu, David Ames, 'Old age psychiatry Down Under' *OAP* (2011) 53: 37 .

Fig 19. 'Arie Course', Melbourne, 1989

Participants and teachers:

(L-R) Stephen McLean, Edmund Chiu, Chris Gilleard, Daniel O'Connor



Source: Tom Arie

Other international organisations developed, including the Geriatric Psychiatry Section of the World Psychiatric Association and the International Psychogeriatric Association. British psychogeriatrics encouraged effective collaboration.¹³⁰

The formation of the first international academic journal dedicated to psychogeriatrics was also UK led. Its creation sheds light on the workings of UK psychogeriatrics. Publishers recognised the international market for a specialist journal. Rival publishers approached different psychogeriatricians.¹³¹ There was a clear risk of creating competing journals, which might be divisive, when a united effort for a single journal would be more constructive. Rivalry¹³² among the academic leadership was laid aside in the interest of development of the specialty. There was much debate about whether it was the right time for a separate journal, or whether it was better for the new specialty to be promoting its achievements in established broad based journals. The UK psychogeriatricians were cautious,¹³³ but well-tried principles of negotiation,

¹³⁰ Arie to Miss Porter (assist. sec. RCPsych), letter, 27.10.1981 (TA)

¹³¹ *IJGP* correspondence file (TA)

¹³² Raymond Levy, 'An old age psychiatrist at work and play: a research perspective' *OAP* (2011) 53: 33-35 34; Pitt, interview by author (2004)

¹³³ Arie, letters to colleagues, 8.11.1984 (TA)

compromise and openness in clinical service developments which had kept psychogeriatrics afloat were used to establish a single journal. The outcome was the *International Journal of Geriatric Psychiatry (IJGP)* in 1986. Murphy was appointed editor.¹³⁴ Other journals followed in quick succession: the *Journal of Geriatric Psychiatry and Neurology* (USA, 1988), *Zeitschrift für Gerontopsychologie und Gerontopsychiatrie* (Germany, 1988)¹³⁵ and *International Psychogeriatrics* (International Psychogeriatric Association, 1989). More followed in the 1990s. They have continued to flourish.

In stark contrast to the lack of enthusiasm in official circles concerning NHS provision, UK community-based psychogeriatrics was widely acclaimed and emulated abroad. The handful of academic psychogeriatricians also led the way internationally by their teaching and establishing a journal. It is hard to identify any reference to these achievements in DHSS and RCPsych archives: they seem to have been ignored.¹³⁶ Consistent international acclaim makes the difficulties encountered when trying to achieve official recognition, (described in the next chapter), even more surprising, and perhaps contributed to the bafflement of leading UK psychogeriatricians at the response of their own government towards their specialty.

Conclusion

Disciplines other than geriatrics and psychogeriatrics were only just beginning to show interest in older mentally ill people and to discard entrenched therapeutic nihilism. The experience of psychologists was uncannily similar to other old age professions when trying to establishing their discipline. This suggests an ongoing and overarching reluctance to provide specialist input for older people.

The relationship between geriatricians and psychogeriatricians was generally constructive. Authorities, including the DHSS, drew close parallels between

¹³⁴ *IJGP* Editorial Board (1986) 1: 1

¹³⁵ Renamed in 2009: *GeroPsych: Journal of Gerontopsychology and Geriatric Psychiatry*

¹³⁶ RCP/RCPsych, *Care of Elderly People*

the old age specialties. However, sometimes their conclusions seemed biased. For example, they extrapolated the recruitment problems of geriatric medicine onto psychogeriatrics and paid little attention to therapeutic successes. The DHSS also seemed to undervalue achievements such as the international acclaim for UK psychogeriatrics. Although some caution was reasonable, this pattern of emphasis might have contributed excessively to undermining service developments and impeding the recognition of psychogeriatrics as a separate specialty.

Chapter 7

The route to official recognition: challenges and achievements

'psycho-geriatricians' will probably have as hard a struggle for recognition as geriatricians have had.

Dr Duncan Macmillan, 1967¹

In 1977, Arie gave the reasons why psychogeriatrics needed DHSS recognition as a specialty: to create the means to identify gaps in services, obtain information on the implementation of government guidance and advocate for resources for policy implementation.² Data collection, discussed in chapter five,³ was central to the campaign for specialty recognition.⁴

This chapter explains the iterative, convoluted pathway along which psychogeriatrics passed in the struggle for acknowledgement, culminating in recognition as a discrete specialty by the Department of Health (successor to the DHSS) in 1989. Recognition was a major landmark but it could not remove underlying problems, such as continuing negative attitudes towards older people.

Raising the issue: should psychogeriatrics be recognised as an official specialty?

At the first meeting of the GPOA in 1973, the need for separate specialty status was discussed. The question was asked, but not answered, whether old age was a separate specialty like child psychiatry, or the work of a general psychiatrist with a particular interest in old age.⁵ Psychogeriatricians in the 1970s held various opinions on this matter, although this did not split an otherwise unified group of clinicians intent on providing adequate clinical services. Post commented that, clinically, there was no need for a separate specialty: illnesses in old age might present differently but this was part of a continuum and there

¹ Macmillan, 'Problems of a geriatric mental health service' 175

² Arie to Royal Commission, letter (draft?), April 1977 (TA)

³ Pages 246-249

⁴ John Wattis to Jim Birley, letter, 11.8.1987 (RCPsychA)

⁵ GPOA, minutes, 9.2.1973, 4 (RCPsychA)

was no clear dividing line between middle and old age. Psychogeriatrics lay within general psychiatry, he stated, and the only reason for separate recognition was to ensure adequate training and facilities which was a political need. Blessed was concerned that separate status could result in professional isolation 'from the general body of unwilling psychiatrists who wish to reject the elderly'. Pitt commented that the specialty already existed *de facto* and the College should inform the DHSS of this.⁶ Some of these opinions paralleled debates within geriatric medicine, such as about the validity of separating patients on grounds of chronological age.⁷

The GPOA discussed whether to draw the lack of specialty status to the attention of the Royal Commission on the NHS in 1977. However, the Commission's focus was largely on clinical service provision, and it was decided to tackle the issue through the College.⁸

The response of the Royal College of Psychiatrists

Among the leadership of the College, there were undercurrents of opposition to specialty status for psychogeriatrics. The influential Manpower Committee minuted disparagingly that it might create 'a vacuum for unsuitably qualified people' and 'It was necessary to preserve standards and maintain some unity'.⁹ The assumption that no-one would be interested in psychogeriatrics¹⁰ might have contributed to the blunder by the RCPsych and RCP leaderships who planned a meeting about psychogeriatrics in 1979. The date coincided with a meeting of the SPOA, an arrangement with which the SPOA would never have agreed.¹¹ Ignoring psychogeriatricians in this way at the RCPsych in the 1970s recalled Post's position at times at the Bethlem-Maudsley¹² and that of

⁶ Felix Post, Brice Pitt, Garry Blessed, quoted in summary of views about specialty recognition (c.1977) (TA)

⁷ Evans, 'Integration' 1433

⁸ Arie to Pitt, letter, 29.9.1977 (TA)

⁹ Manpower Committee, minutes, 20.12.1973, 'Psychogeriatrics as a career' 49/73 (RCPsychA)

¹⁰ White, 'What's wrong?' 89

¹¹ SPOA to Sir Douglas Black, letter, 6.2.1979; SPOA to Desmond Pond, letter, 7.2.1979 (TA)

¹² Blacker, 'Mentally infirm people' 21 (BMHA)

geriatricians among their physician peers in the early years of geriatric medicine.¹³

A psychogeriatrician represented the SPOA on another influential College Committee, the Joint Committee on Higher Psychiatric Training (JCHPT),¹⁴ which aimed to ensure high quality training for all psychiatry SRs.¹⁵ Theoretically, training could progress without specialty recognition, but, in practice, allocation of training posts was inseparable from it. For example, a discussion at the College Council on part-time training indicated a ‘national surplus’ of general psychiatry trainees. This risked leading to capping of psychogeriatric training posts¹⁶ which were included under the general psychiatry umbrella, despite psychogeriatrics being short of consultants.¹⁷ The SPOA noted in 1980 that the JCHPT was ‘uniformly hostile to the idea’ of psychogeriatric specialty status,¹⁸ giving a variety of reasons, such as psychogeriatrics being unattractive to trainees and the likelihood of recruitment difficulties. This reflected Batchelor’s ambivalence,¹⁹ the views the Royal Commission on the NHS²⁰ and the prevailing perceptions of the DHSS.²¹ Professor James Gibbons, a member of the JCHPT conceded that ‘when successful and enthusiastic competent practitioners worked in this area they were able to recruit the cream of the intake’.²² Perhaps that too expressed a fear observed but not readily acknowledged.

It is uncertain whether the journey towards recognising psychogeriatrics was slower than for other under-valued new psychiatric specialties. Substance

¹³ BMA, Geriatrics Joint Sub-committee, minutes, 24.2.1954, 4 (BMAA)

¹⁴ Klaus Bergmann, ‘JCHPT 23.7.1980’ (RCPsychA, Group into Section)

¹⁵ Bewley, *Madness*, 78

¹⁶ SPOA, minutes, 28.2.1980, 9EC/80 (RCPsychA)

¹⁷ Arie to Peter Jefferys, letter, 19.11.1979 (TA)

¹⁸ Bergmann, ‘JCHPT’ (RCPsychA, Group into Section)

¹⁹ Batchelor, *Policies*

²⁰ *Report of the Royal Commission on the NHS*, 63-64

²¹ Dr Elizabeth Shore to Professor Desmond Pond, letter, 20.2.1980 (RCPsychA, Group into Section)

²² Bergmann, ‘JCHPT’ (RCPsychA, Group into Section)

misuse (drug and alcohol) psychiatry, for example, became a special interest Group in 1978.²³ This too had a slow gestation from the first suggestion for specialist clinics in 1943.²⁴ Like psychogeriatrics, slow development probably reflected the sluggish change in attitudes among professionals and more widely, towards stereotyped and stigmatised people in the community. The Manpower Committee did not envisage consultants specialising in substance misuse full time²⁵ and there were obstacles to providing sufficient high quality training.²⁶ Substance misuse psychiatry, which was proving its worth clinically, experienced ‘frustration related to Department of Health opposition’ concerning its recognition in the 1990s.²⁷ Psychogeriatrics was not alone in facing procrastination by the authorities.

Negotiating recognition, 1979-81

With on-going resource and training difficulties and lack of official data on psychogeriatric services, in 1979 the SPOA requested that the College Council designate psychogeriatrics as a specialty. It was unequivocally recorded in SPOA minutes that this had been ‘agreed in principle’ by Council. However, the Council stated that the final decision should be left until their joint annual meeting with the DHSS, ‘to see what the DHSS felt about it’,²⁸ suggesting that the DHSS had the final veto. On its part, the DHSS indicated that it would ‘be likely to be guided by the College on this matter if it endorsed the Section’s views’.²⁹

²³ Bewley, *Madness*, 101

²⁴ BMA, ‘The Future of Psychiatry: report of the Group of Practitioners of Psychological Medicine of the British Medical Association’ Preliminary (1943) 20 (BMAA, Psychological Medicine Group)

²⁵ Manpower Committee, minutes, 15.7.1975, MSC13/75, 18/75.b. (RCPsychA)

²⁶ RCPsych, ‘Manpower requirements for psychiatrists specialising in alcoholism and drug dependence’ (1975) EC29/75, MSC14/75, 1 (TNA, MH 154/675)

²⁷ RCPsych on-line archive, ‘Substance misuse’ 13
<http://www.rcpsych.ac.uk/publications/books/rcpp/9781904671350/extra9781904671350.aspx>
 accessed 4.2.2014

²⁸ SPOA, minutes, 27.9.1979, 31SPOA/79 (RCPsychA)

²⁹ DHSS/RCPsych, meeting, 27.7.1979, C69/79, EFCC32/79 (TNA, MH 154/935)

Following the RCPsych/DHSS annual meeting in July 1979, deputy CMO, Dr Elizabeth Shore, wrote to the president of the RCPsych early in 1980 giving the DHSS's view:

if psychiatrists specialising in the elderly were to emerge as a separate group of specialists this might carry the implication in everyone's mind that they would take over the burden of the provision of psychiatric services for the elderly mentally infirm with the danger that some general psychiatric care would be withdrawn from the elderly. Should the new specialty not prove to be popular the service needs of the elderly might not be met even to the inadequate extent that it is at present.

The creation of any new specialty adds to the already over rigid hospital medical training and manpower structure and makes manpower planning more difficult particularly if the specialty is relatively small ...

We are, highly appreciative to the growing number of psychiatrists who have elected to devote much of their time to this work ...³⁰

This letter raised reasonable questions which required a response. However, in other ways it was problematic. Addressing it to the president of the RCPsych may have been standard practice, but it prevented the SPOA from responding directly. The letter was critical and offered no constructive suggestions. Psychogeriatricians were already 'a separate group' taking on the 'burden' of psychiatric service provision for older people in the districts where they were appointed, although they were unlikely to regard it as a 'burden', a pejorative term. The fear that some 'general psychiatric care would be withdrawn', might have been true, but the quality and benefits of that care was debatable: observing widespread inadequate old age care by general psychiatrists was a stimulus to the new psychogeriatricians to develop their expertise.

The DHSS did not appear to acknowledge that failing to recognise psychogeriatrics and other emerging psychiatric specialties perhaps contributed to difficulties of recruitment, associated with poorly designed, improvised training schemes and uncertainty about the future of the new specialties and therefore also a doctor's future career.³¹ The observation that more consultant

³⁰ Shore to Pond, letter, 20.2.1980 (RCPsychA, Group into Section)

³¹ Manpower Committee, minutes, 21.2.1979, 1/79, 1 (RCPsychA)

psychogeriatricians were providing more services³² was not fully compatible with the statement that the new specialty might prove unpopular. However, precise historical analysis of the psychogeriatric recruitment argument has so far proved impossible. Failure to distinguish psychogeriatrics from general psychiatry in DHSS data³³ and incomplete minutes, especially of some high-level RCPsych committees³⁴ contribute to this difficulty. At times there were insufficient recruits, but the degree of concern from outside the psychogeriatric field may have been extrapolated from geriatric medicine,³⁵ or other low prestige psychiatric specialties such as mental handicap,³⁶ or may have reflected the personal opinions of the College or DHSS leadership, possibly projecting their own prejudices onto a field in which they would not want to work.

Shore's letter also stated that:

the Department is not wholly happy about the suggestion that the Psychiatry of Old Age be designated as a specialty. I must emphasise that the final decision is one for the profession.³⁷

The RCPsych perhaps felt obliged to conform to the first sentence, despite the assurance of the second, resembling the pressures felt by the RCP in 1988.³⁸

Shore's letter was passed by the College to the SPOA who drafted a paper for Council: 'The problem of specialist status in old age psychiatry'. It stated:

A reconsideration of our position has become necessary in order to respond to the letter ... from Dr E Shore on behalf of the DHSS. There is no doubt reading the letter as a whole that the DHSS would not wish to

³² e.g. Garry Blessed, 'Psychogeriatrics in the nearly frozen north' *SPOA Newsletter* (Dec. 1980) 3-4

³³ Manpower Committee, minutes, 16.2.1984, 4/84.iii. (RCPsychA)

³⁴ e.g. Joint Committee on Higher Professional Training, JCHPT (RCPsychA)

³⁵ RCP, 'Medical care of the elderly'; Evans, 'Integration'

³⁶ JCHPT, minutes, 23.7.1980, 2.a.; Manpower Committee, minutes, 25.10.1973, 38/73 (RCPsychA)

³⁷ Shore to Pond, letter, 20.2.1980 (RCPsychA, Group into Section)

³⁸ Page 320; Raymond Hoffenberg (president, RCP) to Jim Birley (president, RCPsych), letter, 24.11.1988 (RCP, MS4811)

see any disturbance of the status quo, ... the case for specialisation is diluted with faint praise and the case against is more positively stated ... It is regretted that Dr Shore's letter so long awaited fails to discuss in any detail ... technical problems or offers any help in coming nearer to a solution.³⁹

The SPOA's response expressed their disappointment and some tactful criticism of the DHSS, but was perhaps designed not to upset the College/DHSS relationship. It is not known if the paper was sent to the DHSS. The College's handling of the situation may have been politically motivated, in the sense of not wanting to challenge the DHSS. Henry Yellowlees, the CMO, later commented: 'I am relieved that the College has rejected a new specialty!'⁴⁰

Through 1979 and 1980 the DHSS and the RCPsych played ping-pong with psychogeriatrics. Concerning the relationships between the DHSS, the College leadership and the SPOA,⁴¹ Rosen's analysis of how medical specialties develop, almost inevitably upsetting established practices and de-stabilizing relationships,⁴² seems apposite.

Achieving recognition, 1987-89

In 1987, the recognition campaign was revived along two fronts: between the SPOA and the RCPsych leadership, with a separate initiative by the RCP.

In 1987, Wattis, then SPOA secretary, wrote to the president of the RCPsych, Jim Birley, highlighting the lack of official data.⁴³ Birley, citing support from the HAS, proposed 'that the College initiates moves to define Psychiatry of Old Age as a separate sub-specialty'.⁴⁴ This proposition contrasted with that of his

³⁹ SPOA, 'The problem of specialist status in old age psychiatry' (1980) EFCC19/80, C32/80 (RCPsychA, Group into Section)

⁴⁰ Henry Yellowlees to Gerald Timbury (Registrar, RCPsych) letter, 9.12.1980 (RCPsychA, Group into Section)

⁴¹ Robert Kendell to Kenneth Rawnsley, letter, 30.6.1980 (RCPsychA, Group into Section)

⁴² Rosen, *Specialisation*, 67

⁴³ Wattis to Birley, 11.8.1987 (RCPsychA)

⁴⁴ Jim Birley, memo, 23.12.1987, EFCC13/88 (RCPsychA)

predecessor, Bewley, who had been unenthusiastic about specialty status and specialist training.⁴⁵ What stimulated the change in the College's response is unclear. It may have been the sheer persistence of the SPOA, evidence that the specialty was growing, the RCP's recent involvement or that Birley already had a constructive interest in the specialty.⁴⁶

Strong feelings about recognition were reflected in a SPOA debate in June 1988. The turnout for this event in London was impressive: 113 participants, mainly psychogeriatric consultants, when there were fewer than 280⁴⁷ in the entire UK. The vote was 101 in favour of specialty recognition, seven against and five abstentions.⁴⁸ The psychogeriatricians envisaged many advantages, with few administrative drawbacks,⁴⁹ although they acknowledged that some changes would be necessary to restructure general psychiatry training and ensure that psychogeriatric training would be led by psychogeriatricians.⁵⁰

Shortly before Wattis approached Birley, Sir Raymond Hoffenberg, president of the RCP, established a working party on psychogeriatric services, advancing from the SPOA-RCPpsych-DHSS stalemate. There is evidence from the inaugural meeting minutes that it was convened because of senior physicians' anxieties about older, mentally unwell people.⁵¹ Pitt, then SPOA chairman, expressed this more bluntly, arguing that the motivation came from 'disgruntled physicians' desiring to remove demented patients from their wards.⁵² Nevertheless, the RCP had shifted from its earlier stance, when, in

⁴⁵ Pitt, interview by author (2004); GPOA, minutes, 30.10.1975, 5.h. (RCPpsychA)

⁴⁶ Birley, 'Smell of success'

⁴⁷ Arie and Jolley, 'Psychogeriatrics' 262

⁴⁸ SPOA, minutes, 16.6.1988, 9SPOA/88 (RCPpsychA)

⁴⁹ Wattis, 'Working party'

⁵⁰ Tom Arie, 'Should psychogeriatrics be a specialty?' (1988) 4 (RCPpsychA, Specialty recognition)

⁵¹ RCP/RCPpsych working party, 15.4.1987, 5 (RCP, MS4811)

⁵² Pitt (BLSA)

1977, it stated that planning psychogeriatric services ‘was the province of the Royal College of Psychiatrists’⁵³ and clearly wanted little to do with it.

Hoffenberg initially chaired the working party, further raising the standing of the discussions. He invited Bewley to join.⁵⁴ Bewley subsequently took over as chairman, after his term of office as president of the RCPsych expired.⁵⁵ Both Bewley and Hoffenberg remained committed to the working party, although the psychogeriatricians and Isaacs guided its direction and compiled most of the report.⁵⁶ As with *The Rising Tide*, the content of the meetings was old ground for the psychogeriatricians.⁵⁷ The objective was ‘to *implement action* on the betterment of care and training in the field of care of the elderly mentally ill’,⁵⁸ (italics in original) with the expected outcome that ‘any joint report by the RCP and the RCPsych, would have a positive impact on the DHSS and related services’.⁵⁹

Hoffenberg was the ‘first non-psychogeriatrician on the working party to state that Psychogeriatrics should now be a specialty in its own right’, and his endorsement was greatly appreciated by the psychogeriatricians.⁶⁰ Recognition as a specialty was recommended as a means to facilitate service developments, education, training and research and was justified by referring to the number of consultants and service patterns (largely based on Wattis’s surveys⁶¹), training requirements and the body of knowledge and research,⁶² all reasons for recognition proposed previously by the SPOA.

⁵³ RCP, *Report of the Working Party on Medical Care of the Elderly* (1977) 9 (WL/PP/DOL/A/1/12: Box 2)

⁵⁴ Thomas Bewley, letter, Sept. 2012

⁵⁵ RCP/RCPsych working party, 15.4.1987, 3 (RCP, MS4811)

⁵⁶ *Ibid.* Jan-Nov 1987 (RCP, MS4811)

⁵⁷ *Ibid.* terms of reference, 26.1.1987 (RCP, MS4811)

⁵⁸ RCP/RCPsych, *Care of Elderly People*, 1

⁵⁹ RCP/RCPsych working party, 26.1.1987, 2 (RCP, MS4811)

⁶⁰ Colin Godber to Raymond Hoffenberg, letter, 1.11.1988 (RCP, MS4811)

⁶¹ Wattis, ‘Geographical variations’; RCP/RCPsych, *Care of Elderly People*, 3, 23

⁶² RCP/RCPsych, *Care of Elderly People*, 21

The joint RCP/RCPsych endorsement was impossible for the DHSS to ignore. Neither the SPOA nor the RCPsych appeared to have sufficient clout to achieve this alone, which raises questions about the authority of the psychiatric leadership in the wider medico-political scene at that time.

The RCP probably contributed to the low media coverage when the working party's report, *Care of Elderly People with Mental Illness*, was published. The RCP had recently hosted a press briefing for a report on neonatal medicine which, Hoffenberg revealed, 'got presented in such a distorted way in the press that day and led to an outburst from the Secretary of State'.⁶³ There was concern that the same might happen to this jointly published report on psychogeriatrics. Hoffenberg commented:

If the press come ... they will turn it into a Government-bashing session ... They will latch onto the fact that the elderly mentally ill have not been well looked after and might easily manoeuvre us into the position of appearing to blame the Government.⁶⁴

Although press distortion might have been a valid reason, this indicated a clear message, similar to that of the RCPsych in its response to Shore's letter in 1980: Royal Colleges were reluctant to risk annoying the government. Perhaps the view was justified as it might have reduced the Royal Colleges' influence and credibility in future negotiations. Hoffenberg added: 'I am worried that the report does not have enough in it to justify the calling together of a large number of representatives of the press'.⁶⁵ It was therefore unsurprising that, despite being relevant to the health of a large sector of the population, the report received little coverage in the national press. The *Guardian* cited it on pages eight and 26.⁶⁶

⁶³ Hoffenberg to Birley, letter, 8.12.1988 (RCP, MS4811)

⁶⁴ Hoffenberg to Birley, letter, 24.11.1988 (RCP, MS4811)

⁶⁵ *Ibid.*

⁶⁶ David Brindle, 'More psychiatrists urged for elderly' *Guardian*, 24.2.1989, 8; Anon. 'Caring questions' *Guardian*, 24.2.1989, 26

Reception of the new specialty

Subsequent Department of Health recognition of psychogeriatrics was also generally overlooked. The new specialty was noted in the House of Commons on 4th April 1989: 'Psychogeriatrics has been established recently as a separate specialty and there are plans to collect manpower figures in the future'.⁶⁷ No references to this have been identified in the *Times*, *Guardian* or *Observer* newspapers.

Not all psychiatrists welcomed the new specialty. Professor David Goldberg (knighted 1996), appeared to show little interest when specialty status for psychogeriatrics was announced at the RCPsych Manpower Committee, stating that his main concern was the difficulty of providing services with limited resources for the largest group of mentally ill patients, adults under 65.⁶⁸ Undoubtedly, younger people also had difficulty accessing services,⁶⁹ but Goldberg could have stated that resource issues applied to everyone. His response resembled earlier patterns: prioritise younger over older, despite clinical and humane arguments that equitable and age-appropriate services were required and beneficial.

Conclusion

The need for recognition was largely driven by the SPOA's difficulties in obtaining official data necessary to ensure service development. The Department's reluctance to recognise psychogeriatrics was based on envisaged administrative difficulties, rather than on existing evidence that a dedicated, expanding workforce was benefiting the wellbeing of older people. The RCPsych condoned the DHSS's stance.

⁶⁷ David Mellor, 'Psychogeriatrics' HC, *Hansard*, 4.4.1989 Written answers to questions: Col.80 <http://www.publications.parliament.uk/pa/cm198889/cmhansrd/1989-04-04/Writtens-6.html> accessed 15.6.2011

⁶⁸ Manpower Committee, minutes, 14.2.1990, 5.a. (RCPsychA)

⁶⁹ HC Select Committee, *Community Care*, xxii-xxiii

The situation was resolved when the highly influential RCP intervened, and, together with RCPsych and SPOA representatives, assembled recommendations which the Department of Health could not ignore.

Official recognition, however, could neither dispel disparaging attitudes towards the new specialty held by influential general psychiatrists nor counteract widely held prevailing lack of interest and negative ideas towards older mentally ill people.

Chapter 8

Conclusion

If we do not now provide adequate treatment and care for older people with mental disability, it is because we, as a society, deliberately choose not to do so – a decision which we as individuals may one day bitterly regret.

Alison Norman, CPA, 1982¹

This study analysed the history of psychogeriatric service development in its societal context. Widely held values influenced health and social care provision, including the development of psychogeriatric services, NHS resource allocation and attitudes of professional staff. Epidemiological, clinical and scientific research increasingly underpinned psychogeriatric practice. From a starting point *circa* 1940 of little useful clinical knowledge, no specific services and inadequate psychiatric assessment and interventions, much had been achieved by the late 1980s when dedicated, evidence-based psychogeriatric services were available to 70% of the population.

This chapter addresses the degree to which the research objectives were achieved, the findings arising from the initial research questions,² the relevance of the findings to current policy making and ideas for future research.

Were the research objectives achieved?

The historiography outlined in the Introduction, undertaken by clinicians or professional historians, was often incomplete or biased. The present study was undertaken by a clinician with training in history, and aimed to achieve an impartial account. Overall, the main objectives, based on the research questions, were achieved, and the outcomes are discussed below (pages 325-337). This section reviews the limitations and gaps.

Not all aspects of the subject could be analysed in equal depth. Psychogeriatrics has been almost completely unexplored historically and

¹ Norman, *Meeting the challenge*, 124-125

² Page 18

relevant government plans took decades to be implemented, hence a broad overview was appropriate and justifies the time frame – a period of 50 years – chosen for this study. This risked reducing the depth to which some aspects could be analysed compared with investigating a shorter time period. However, the lengthy time span was valuable for revealing consistent patterns of response, an important finding for understanding the reasons for reluctant service provision and relevant to future policy making.

Lack of availability of archives limited the analysis of intra-governmental policy processes.³ Lack of space limited more detailed exploration of clinical developments. It would also have been desirable to pay more attention to patient and staff experiences. Reasons for the lack of patient and carer perspectives, and the absence of oral history interviews with non-psychogeriatricians, all of which might have contributed to a greater ‘bottom-up’ and clinical understanding were discussed earlier.⁴ These aspects of the history of psychogeriatrics require different approaches from those employed in the thesis and warrant future research.

It was sometimes difficult to reconstruct events and their chronologies from the sources available. Historical analysis shares the experience of some psychogeriatric leaders at the time: it was sometimes difficult to be sure about what was happening. For ascertaining chronologies, difficulties included discussions about a single issue taking place between different players concurrently; initiatives spoken or written about, including at central government level, not necessarily reaching fruition; and journal articles, on which this thesis draws heavily, often having a variable time lag between identifying an outcome worth reporting and its publication. Also, archived minutes of committees were often incomplete, with supplementary discussion papers missing.

³ Pages 42-43

⁴ Pages 48-50

More comparisons with other psychiatric specialties in England, such as substance misuse or mental handicap, might have helped clarify obstacles to development, e.g. whether ageism was as much a barrier as it appeared to be. However, neither primary nor secondary sources were readily available to do this. In addition, a broad study of a national phenomenon risks over-generalisation: to remedy this, multiple, in depth local studies would be needed to explore individual services. This might help overcome potential bias of successful services being publicised, but failed innovations remaining unreported outside local archives.

As I searched published sources and archives in the course of research, evidence for recurrent ageist and defeatist attitudes shocked me. If the impression given in this study is that the overwhelming attitude to chronically and/or mentally ill older people was negative, it is not for want of thorough dispassionate searching.

It was not possible to study all possible perspectives on the topic within the time and space available for a PhD thesis. Perhaps the approach of this study reflects the eclectic, holistic multi-disciplinary method of psychogeriatrics itself, drawing on numerous resources and seeking to offer a comprehensive and balanced approach in an environment where ideal resources are insufficient or unavailable.

The services

Research question 1: Why were psychogeriatric services needed? How did they develop between c.1940 and 1989? How did specialty recognition come about? What was achieved by 1989?

Why were psychogeriatric services needed?

By the 1940s, mental hospital beds were increasingly and disproportionately occupied by people over 65. That was partly due to more people living longer and suffering from chronic degenerative psychiatric disorders, but was also due to inappropriate admissions, defeatist attitudes towards treatment and rehabilitation and under-provision of community services. In the 1960s, continuing high death rates soon after admission, ‘warehousing’ of long-stay

patients, and scandals highlighting degrading management of vulnerable patients called into question the suitability of existing services. Evidence that older people could benefit from high quality psychiatric services, and the government's belief that new services were financially preferable because they were theoretically cheaper, contributed to arguments for dedicated community and DGH services.

How did they develop between c.1940 and 1989?

Creating services for older people was logical, but was it feasible? Lack of clarity by the government about where responsibility lay for psychogeriatric services – with psychiatric, geriatric or social services – continued from the 1940s until the 1980s. Government directives to provide for mental disorder in old age were well intentioned but hardly implemented. Interventions such as rehabilitation and community services were offered inequitably to older and younger people (favouring the latter), taking account of evidence of their ability to benefit.

Evidence of the benefits of making accurate psychiatric diagnoses and providing treatment, rehabilitation and community support for older people with psychiatric disorders began to emerge in the 1940s. However, the titles of the 1950 Ministry of Health directives on older people's health refer to *treatment* for physical illness and *care* for mental disorders, suggesting defeatist attitudes towards active interventions for the latter. Studies indicating the possibility of reducing hospital bed use by older mentally ill people in the 1940s and 1950s were less conclusive than for physical illness. Nevertheless, it was unfortunate that the government did not encourage adoption of principles of geriatric medicine in mental hospitals.

As expected with technological clinical advances, new psychiatric medications in the 1950s were adopted enthusiastically, and the Mental Health Act 1959 was necessarily implemented rapidly. Both largely related to younger people but had the potential to benefit older people. Non-mandatory, psycho-social changes, or those which challenged established practice, such as Roth's classification system, took longer. In the 1950s and 1960s, innovative

psychogeriatric services were rare, relatively isolated and adopted different models; Post's functional illness ward and Cosin's psychiatric service within geriatric medicine were probably unique. It is unfortunate that Robinson's scheme in Scotland was not drawn to the attention of the English authorities. However, it inspired some clinicians south of the border, including Barton and Whitehead, but their comprehensive service held little constructive significance for the Ministry. Messages of psychogeriatric therapeutic success largely spread by word of mouth between clinicians, an inevitably slow process, especially when it concerned an under-valued sector of the community.

In 1970, the DHSS 'discovered' psychogeriatric services which led to provision of potential solutions for their concerns at the requisite time. Clinician-DHSS links led to HM (72)71 in 1972 which formalised plans for comprehensive community and hospital services. It provided a framework within which clinicians could negotiate with the government and other institutions. However, like earlier and later proposals, it was not mandatory. Nationally, developments remained haphazard rather than planned and incremental. The comprehensive service model seemed to suit the general psychiatrists; the psychogeriatricians worked with as many older people as the size of their service permitted. General psychiatrists, reluctant to treat older people, were, however, unwilling to share their limited resources to assist the process.

Older people left the psychiatric hospitals as they closed, after younger people. They tended to be provided with facilities of lower standard, even when dedicated psychogeriatric services began to multiply. An unanswered question is whether there would have been further delays in providing for older people if psychiatric hospitals had not been forced to close.

Negative attitudes, or at best indifference, towards older people, by the medical profession, policy makers and in society more broadly, probably hindered developments. Investment in older people's services by local authorities was frequently half-hearted. Incredulity by people in authority that staff would want to work with mentally unwell older people also helps to explain the reluctance to provide services.

The disinclination of the authorities to act was a recurring problem throughout the 50 years covered in this thesis, despite evidence of benefit for patients and carers and increasing enthusiasm from involved professionals. However, perhaps the slow speed of development, coupled with the diversity of approach, also permitted comparisons and evaluations which ultimately improved the strength of service design.

With more knowledge about how to improve older people's mental wellbeing, it is difficult to explain, except in terms of age discrimination, why their needs continued to be so neglected. Obstacles showed little evidence of abating and Arie's comment in 1970 continued to ring true: 'the elderly and the chronic sick, even in Utopia, are still somehow [likely] to be at the end of the queue'.⁵

How did specialty recognition come about?

Official recognition of psychogeriatrics as a specialty was essential to ensure that the DHSS collected specific data about psychogeriatric services. The recognition process was tortuous and characterised by negative and obstructive views from the DHSS and RCPsych, despite evidence of clinical effectiveness. The RCPsych and DHSS seemed driven by legitimate but excessive administrative concerns. It is an indictment of the DHSS and RCPsych that the RCP had to intervene to validate the new specialty. Overall, the SPOA-RCPsych-RCP-DHSS dynamics confirm the impression that professionals advocating for mentally ill older people were frequently marginalised and not taken seriously by professional colleagues and health service leaders.

What was achieved?

In the 1960s and early 1970s, when some age-based hospital data were collected, reduced hospital bed occupancy probably reflected beneficial outcomes from the few new services. Later, similar data were less valid due to the effects of government targets for closing psychiatric hospitals and opening private care homes without necessarily providing adequate community

⁵ Tom Arie quoted in DJ Searle, 'The psychogeriatric services: report of a conference held at the Hospital Centre, London on Sept 9th' *Nursing Mirror*, 25.9.1970, 10-11 11; Arie, e-mail, 10.6.2013

psychogeriatric alternatives. However, although demand for institutional care was complicated, the fairly constant 5% of people over 65 living in long-stay institutions, despite increasing longevity and more chronic disorders, suggests a helpful contribution from dedicated services working with patients and their families. Formal clinical studies indicated the effectiveness of specific interventions and achievements of high quality psychogeriatric services were evident through independent analyses including by the HAS and CPA in the early 1980s.

In 1986, 70% of the population had access to psychogeriatric services, a major achievement. However, without centrally collected government data, precisely how many services of any sort existed, and their clinical outcomes, were unclear. No district yet offered the full range of services for comprehensive health care in old age. In the absence of a full range, it was difficult to know their potential for effectiveness. By 1989, other achievements included more university appointments, a UK-led dedicated international journal and acclaim of the UK model of psychogeriatrics abroad. All these should have given credibility to the specialty. However, the authorities were consistently reluctant to support it.

The RCP/RCPsych report (1989) acknowledged the achievements while realistically emphasising that more was required to ensure high quality services throughout the NHS. Perhaps White's description was apt: the specialty had become 'semi-respectable (I doubt if we can ever be totally respectable to our colleagues)'.⁶

The players

Research question 2: Which individuals, professions and institutions led the developments? What or who helped or hindered them?

Individuals, professionals and institutions are considered in turn. Some professions were male or female dominated, so gender, as it might have related to service development, is also explored.

⁶ White, 'Moving on' 12

Individual leadership

From the 1940s until the early 1970s a few psychiatrists wrote about their work with older people, including in high status medical journals, but this did not capture the imagination of colleagues or the government or spur them into action. Commentators in the 1980s noted that services flourished when led by enthusiastic individual psychogeriatricians.

Throughout the period studied, interest spread through face-to-face teaching in innovative units, such as from Post's work at the Bethlem-Maudsley. The 'ripple effect' of enthusiastic activity was vital to development. Some, who eventually became the most committed to the specialty, such as Post, began with negative expectations. Their 'conversion' may have added fervour to their teaching and their writing. Research in the 1980s supported earlier informal observations that rewarding experiences of psychogeriatric practice for students and junior staff could influence their career choices.

In determining who created the specialty, it is important to acknowledge certain people. Five psychiatrists stand out for their creativity and actions in laying the foundations of the specialty: Aubrey Lewis, Martin Roth, Felix Post, Sam Robinson, and Tom Arie. Lewis, with enormous foresight, established the pioneering Geriatric Unit at the Bethlem-Maudsley. Roth was a meticulous researcher who, in particular, transformed the widely assumed unitary diagnosis of 'senility' into a range of common psychiatric diagnoses which had different clinical outcomes. Post demonstrated the effectiveness of treating functional disorders, by his follow-up studies and in his clinical teaching, and inspired junior colleagues who became the next generation of psychogeriatricians. Robinson established the first dedicated comprehensive psychogeriatric service. Although Lewis and Roth had contacts in government circles, they did not promote the cause of psychogeriatric services in a consistent or compelling way. Neither Post nor Robinson became spokesmen for service development beyond their own institutions until becoming chairmen of the GPOA/SPOA later in their careers. In contrast to his predecessors, and helped by the timing of the reports of his clinical outcomes, Arie had the political aptitude to become a credible force within the DHSS advocating for

psychogeriatric services nationally. These five could perhaps be described as making pivotal contributions, changing the direction of psychogeriatric service development, much as Warren shifted ways of thinking about physical illness in old age. Naming a few individuals does not minimise the contributions of many other vibrant clinical leaders who pushed the services forward, creating, improving and evaluating local services, contributing to GPOA/SPOA activities, carrying out research, encouraging and supporting colleagues and educating professionals and carers about the specialty.

The motivation for some doctors choosing careers in psychogeriatrics, widely regarded as an unrewarding field, needs consideration. Murphy commented that some psychiatrists were drawn into the field by ‘witnessing the unmet demands on our local health and social services and experiencing an urge to “do something about it”’.⁷ Some participants in the witness seminar indicated possible origins for their motivation, including religious ideals, relationships with their grandparents in childhood, an inspiring teacher in the subject, or rewarding clinical experiences early in their careers.⁸ Personal histories, including of discrimination or persecution, might have influenced career decisions, leading some doctors to work with people also experiencing discrimination. Roth, Lewis, Mayer-Gross, Stengel, Post, Bergmann and Arie were all immigrants; the latter five were refugees from Nazi Europe. Post-war, prestigious hospital medical specialties tended to exclude refugees,⁹ which influenced Post’s decision to enter psychiatry¹⁰ and inhibited him from opposing Lewis’s proposal that he lead the Geriatric Unit.¹¹

In the 1940s, geriatricians – especially Warren, Cosin and Amulree – and researchers into community need – Sheldon, Rowntree and Goldschmidt – laid the foundations for subsequent psychogeriatric services, probably rather more than the majority of psychiatrists who were their contemporaries. The leaders

⁷ Elaine Murphy, ‘The new journal, its present state and prognosis’ *IJGP* (1988) 3: 77

⁸ ‘Witness’ 69-96

⁹ Cooper, *Pride versus Prejudice*, 222-223

¹⁰ Post, interviewer unknown (FP)

¹¹ Post, ‘In the beginning’ 15

of geriatric medicine in the 1960s and 1970s – such as Williamson, Isaacs and Anderson – supported the emerging psychogeriatricians and recognised the importance of dementia in generating service demands. Whereas Post and Roth’s *clinical* teachings are still discussed among old age psychiatrists today, and Warren and Amulree are remembered prominently by geriatricians, others whose contributions underpinned psychogeriatric service design have been largely forgotten. Those whose contributions have been recalled in this thesis were markedly determined individuals, dedicated to their cause and prepared to surmount obstacles rather than be thwarted by them.

Professional leadership and gender

Psychogeriatricians prioritised older people. Passionate about their work, they developed an enthusiastic workforce with high morale and positive expectations contributing to improved clinical outcomes. They encouraged students and staff to experience the rewarding nature of the work and demonstrated the fallacy of commonplace ageist assumptions. The new psychogeriatricians risked bewilderment, disagreement, unpopularity and opposition from colleagues, but offered camaraderie, inspiration and encouragement to those who wished to join them.¹² No other professional group took a similar, optimistic, forceful and consistent leadership stance locally and nationally concerning older people with all types of psychiatric disorder, advocating on their behalf for an equitable share of resources and ultimately bringing about the provision of services country-wide. Negative perceptions of psychogeriatric work, including from government and clinicians outside old age health services, indicated lack of understanding of its tasks, challenges, rewards and achievements.

Doctors took the lead in developing medical specialties and clinical services.¹³ The established status of the medical profession may have helped them to advocate for older people and build up dedicated services in contrast to the

¹² Claire Hilton, Tom Arie, Malcolm Nicolson, ‘A witness seminar: the development of old age psychiatry in Britain, 1960-1989. Themes, lessons and highlights’ *IJGP* (2010) 25: 596-603 597; Arie, ‘Remembering Felix’

¹³ Pages 23-24, 190-192

newer professions, including modern nursing, social work and psychology, which were seeking to establish their own professional roles during the mid- to late twentieth century. However, other factors may have contributed to lack of multi-disciplinary involvement in service development. For social workers, the shift from specialized to generic social work following the Seebohm report (1968) may have reinforced indifference to low prestige old age work. Leadership by social workers, a largely female profession who were trained to be non-judgemental, might also have been inhibited by gender stereotypes when interacting with a male dominated medical profession. The effects of gender, however, probably applied less to psychology and nursing. Psychology evolved with a more equal ratio of men and women, but any psychologists for older people were rare in the 1980s, permitting little organisational contribution from them as a profession. In psychiatric nursing, unlike traditional nursing, a high proportion of psychiatric nurses were male, since psychiatric hospitals which segregated male and female patients also separated nursing staff. Lack of contribution by nurses was probably more related to professional status than gender.

‘Great men’ predominate in this study with few ‘great women’. However, taking account of the size of the specialty of psychogeriatrics and the gender ratio within the medical profession, the small number of female doctors seems proportionate. More women were accepted into medical school following the Sex Discrimination Act (1975). They would not have started to qualify until 1980 and were unlikely to have sought consultant posts before the late 1980s. Within geriatric medicine, Warren and Woodford-Williams have been mentioned, and female doctors in high positions in the Ministry/DHSS included Winner and Shore. Within psychogeriatrics, Murphy took an academic lead, and more women achieved prominence in the specialty in the 1990s, such as Nori Graham and Susan Benbow. Arie encouraged women to enter the field.¹⁴ Women doctors in the early 1970s working with him at Goodmayes were known as ‘Tom’s girls’.¹⁵ This was not then interpreted as a sexist description,

¹⁴ Tom Arie, ‘Married women doctors as part-time trainees’ *BMJ* (1975) iii: 641-643; Graham, ‘Witness’ 43-45

¹⁵ Hilton *et al.* ‘A witness seminar’ 598

and women consultant psychogeriatricians at Goodmayes in 2011 were proud to use their historically-rooted designation, ‘Goodmayes girls’.¹⁶ In other professional groups, Goldschmidt in social work and Margaret Eysenck in psychology were active in the very early days. Altschul, a nurse, and Robb, a psychotherapist and campaigner, influenced psychogeriatric service development tangentially. The presence of other women is detectable from a close scrutiny of the bibliography of this thesis.

Institutional leadership

Creating change in psychiatric hospitals was perhaps hindered by rigid hierarchical organisational structures which contributed to maintaining the *status quo*. Successive governments appeared not to understand that interest and institutional culture could not change overnight. They seemed to assume that staff would do as they were told. For example, they ignored the numerical imbalance between geriatricians and *interested* psychiatrists when proposing and re-proposing joint P-GAUs. Changing culture was difficult in services optimistically using new clinical methods to treat mainly younger mentally ill people who were expected to regain independence; it was harder when providing for older people with mental disorders stereotypically regarded as unlikely to benefit from active approaches.

General hospitals were increasingly centres for high-tech clinical interventions which were valued above the management of chronic and degenerative disorders of mainly older people. Specialists in high-tech medical and surgical fields rarely understood the need for psychogeriatric services, except as a means to vacate beds on their wards. Nor did they understand the specialist nature of psychogeriatric work. Some clinicians warmed to it slowly, including the leadership of the RCP.

‘Stigma by association’ may have linked to the medical profession not taking psychiatrists seriously, and psychiatrists not taking psychogeriatricians seriously, potentially further undermining their credibility. Marginalisation of

¹⁶ Hilary Kinsler, ‘Memories from Goodmayes’ *OAP* (2011) 53: 9-10

psychogeriatricians and their services occurred within the RCPsych and the Ministry of Health/DHSS. Intra-professional relationships were known to become tense when creating new specialties. Within psychiatry, for psychogeriatrics, these difficulties were compounded by ageism, stigma, and the need to compete for limited resources. Perhaps other less tangible factors contributed, such as the intense enthusiasm, camaraderie and work satisfaction of the psychogeriatricians, which psychiatrists in more established fields may not have shared.

External influences

Research question 3: What were the chief influences, from government and wider society, on developing services and gaining recognition as a specialty?

According to the Royal Commission on the NHS (1979), ‘The NHS reflects the society around it’.¹⁷ Responses to mentally unwell older people and to services for them were influenced by psychological, philosophical, social, political and economic beliefs and ideals widely held in society.

Following *Care of the Aged Suffering from Mental Infirmary* in 1950, the government appeared to encourage the clinical work, while failing to recognise the specialty or give it the necessary resources. Since the government expected community care to be cheaper than institutional care, it might have been expected to prioritize older people. Yet they were placed second to younger people for services deemed beneficial, even if those new services might reduce costs. This suggests that chronological age was particularly significant among the values contributing to priority-setting.

Perceived demands on welfare services related to demographic changes and dependency at both ends of life. ‘Too many’ older people in the balance was taken to mean that younger families needed to be prioritised. If the economy and younger people flourished, older people were no longer a ‘burden’, and therefore still lacked priority. Repeatedly, the authorities appeared unaware of,

¹⁷ *Report of the Royal Commission on the NHS*, 356

or disregarded, recommendations to provide psychogeriatric services. Poor service provision was concealed, such as when long-stay mental hospital wards were excluded from surveys concerning facilities for older people. Hiding or ignoring the challenges might unintentionally, or deliberately, conveniently delay financial commitment. Whether that would ultimately save money was unclear, and there is no evidence that it was considered.

There was no obvious attempt to reduce the acknowledged shortfall of older people's NHS and social care services. Recommendations from government appointed committees which might have improved the situation were repeatedly rejected. NHS reorganisations, despite worthy objectives and potential for improving chronic illness and old age services achieved little. 'Integration', a buzz-word of reorganisation, did little to enhance service provision by coordinating older people's services. Integration seemed to mean achieving the maximum clinical activity with least expenditure, especially for people deemed economically un-productive suffering from chronic disorders. How improvements were supposed to occur was unclear. The combined fears of old age plus mental illness, and the cultural tendency to distance oneself from them, may have had a greater impact on psychiatric services than the less stigmatising effect of physical illness on geriatric services, creating recoil rather than constructive response.

Ageism in the course of this research was often revealed only by subtle clues from pejorative language, but perhaps contributed to undermining policies and provision. In 1970, Simone de Beauvoir, the philosopher, wrote that it was 'astonishing' that modern society did not attempt to tackle the difficulties of old age because they affected the future of most societies.¹⁸ Existential theories relating to ageing and ageism may help to explain the recurring and hardly changing attitudes towards providing psychogeriatric services until 1989, with little evidence of improvement since.¹⁹

¹⁸ Simone de Beauvoir, *Old Age*, tr. Patrick O'Brian (Harmondsworth: Penguin Books, 1977) 243 (French edition, 1970)

¹⁹ David Anderson *et al.* 'Mental health service discrimination against older people' *The Psychiatrist* (2013) 37: 98-103

Government decision making is complex and based on many influences including the competing interests of various stakeholders. However, it is difficult to understand why, given the research evidence demonstrating needs and benefits from services, successive governments were reluctant to resource them. Their responses seemed characterised by lack of interest and insurmountable defeatism. Permissive guidelines, together with concerns that increasing numbers of older people would require even more age-appropriate services, seemed to discourage provision. Reactive government responses were linked to newsworthiness and public pressure which tended to be short lived. In the early 1980s, when improved demographic evidence for prolonged good health in old age became available, it was hardly incorporated into economic analyses or service planning. Changes in funding, together with proposals for ‘society’ to be central to providing care and support to mentally ill older people, reinforced the notion that governments lacked the intention, understanding or means, to provide comprehensive services. While the high cost of longevity was maximised in political and public discourse, other influences on NHS costs, such as technology, salaries, and end of life care at any age, were minimised. The humane, and potentially beneficial, financial consequences of keeping older people as fit as possible, and consequently more active and less dependent on others seemed not to be recognised. Enlightened policies often remained just good intentions. The widely cited and variously attributed cliché that the mark of a civilised society is the way it treats its vulnerable members reflected uncomfortably on levels of compassion afforded by government, NHS and social care authorities towards mentally unwell older people.

Relating historical analysis to current policy and practice

Key themes in public health policy and practice recur and are re-addressed by each generation.²⁰ Some reiteration of themes is inevitable and desirable in the context of material changes in society and new medical discoveries. But attitudes in society can be slow to change and some deep-seated cultural beliefs

²⁰ Joceline Pomerleau, Martin McKee, *Issues in Public Health* (Maidenhead: Open University Press, 2005) 12

endure, which, although not reproduced identically at different times, provide antecedents to public resistance to health innovation. Historical analysis can help clarify this process.²¹

Health policy analysts have commented that ‘policy makers are constrained from behaving rationally in many ways’, for example, they are not value-free and are faced with influences from past policy which may restrict options.²² This reinforces the need to reflect on the history of the policy issues concerned, in order to retain the benefits of previous experience and encourage rational decision making. This remains important for current service provision: battles for resources persist and appropriate services for older people still lag behind those for younger people.²³ A survey of health service commissioners in 2010 identified a disconcerting pattern of government response, similar to the findings of this thesis:

Governments and commissioners have shown a surprising failure to realise the significance of the ageing population, adopt best practice and make service development for older people a national priority.²⁴

The Equality Act (2010) made it unlawful to discriminate in the provision of services on the grounds of age,²⁵ but this, like all legislation, is open to interpretation and its impact thus far is uncertain.

Since this research is historical, the past tense has generally been used, although ‘and ongoing’ could be appended to many statements. In many places, services improved during the 1990s and early 2000s, but many of the underlying problems which faced the specialty until 1989 remain:²⁶ recognition

²¹ Virginia Berridge, ‘Thinking in time: does health policy need history as evidence?’ *Lancet* (2010) 375: 798-799

²² Gillian Walt, *Health Policy: an introduction to process and power* (London: Zed Books, 1994) 47-48

²³ e.g. Claire Hilton, ‘Psychological therapies, older people and human rights’ *Psychiatric Bulletin* (2009) 33: 184-186

²⁴ Anderson, ‘Mental health service discrimination’ 103

²⁵ Equality Act 2010, chapter 15

²⁶ Claire Hilton, ‘Sans teeth, sans eyes, sans taste, sans everything: resourcing mental health services for older people’ *JRSM* (2012) 105:146-150

was more a milestone than a destination. Ongoing problems include ageist attitudes,²⁷ insufficient clinical research involving older people,²⁸ and chronic under-funding and under-provision of services despite government rhetoric about improvements.²⁹ The tendency to scapegoat older people for excessive use of resources persists.³⁰ Rarely, reports appear suggesting that older people are not the main reason for escalating health care costs.³¹ Attitudes differ between European countries facing similar demographic changes. For example, a survey of 1,113 health care professionals across more than 13 European countries by the Economist Intelligence Unit in 2011 explored whether ageing was seen as a threat to the viability of each country's health system. Sample sizes were inevitably small so the findings may not be representative. However, the study identified marked differences between countries in their acceptance of demographic shift: Scandinavian countries were the most accepting and the UK the least.³²

In the past, NHS reorganisations did not achieve improved services for older mentally ill people and future reorganisations are unlikely to be more effective. With these services consistently under-provided, there is a growing gap to fill, and inhumane provision to be remedied. Familiar arguments persist: in 2014, the impossibility of providing NHS services for unwell older people appeared as a front page headline in a national newspaper.³³ The present study aims to help compensate for the lack of NHS and Department of Health institutional

²⁷ Desmond O'Neill, 'The art of the demographic dividend' *Lancet* (2011) 377: 1828-1829

²⁸ Geoff Watts, 'Why the exclusion of older people from clinical research must stop' *BMJ* (2012) 344: 23-24

²⁹ BBC News, 'Dementia: PM promises push to tackle 'national crisis'' 26.3.2012 <http://www.bbc.co.uk/news/health-17507678> accessed 19.5.2012

³⁰ RCP, *Hospitals on the edge? The time for action* (2012) 3 <http://www.rcplondon.ac.uk/projects/hospitals-edge-time-action> accessed 11.12.2012

³¹ John Appleby, *Spending on Health and Social Care over the next 50 years: why think long term?* (London: King's Fund, 2013) ix

³² The Economist Intelligence Unit, *A New Vision for Old Age: rethinking health policy for Europe's ageing society* (London: The Economist, 2012) 1, 11, 39

³³ Denis Campbell, 'NHS could be 'overwhelmed' by people with long-term medical conditions' *Guardian*, 3.1.2014, <http://www.theguardian.com/society/2014/jan/03/nhs-overwhelmed-long-term-medical-conditions> (accessed 14.1.2014)

memory, in order to set twenty-first century reports in a meaningful historical context.

Whether this study can achieve a secondary goal of analysing the past to inform future policy remains to be seen. Better understanding of the entrenched position of politicians, civil servants and health and social care professionals and of how past inactivity and obstruction, intentionally or otherwise, contributed to current NHS under-provision, may help to remedy it. In the light of evidence that unhelpful attitudes have hardly changed, historical understanding might point to ways of challenging them. Exploring what worked and did not work, and the associated reasons, especially where repeated patterns appear, may help to identify factors which make for effective policies to enhance psychogeriatric services. Like clinical and scientific research, historical studies are open to further questioning and analysis. Change over time does not invalidate historical input to policy making any more than applying the results of clinical research to individual patients whose circumstances and clinical presentations are not identical with inclusion criteria – such as age – in the original study.

Suggestions for future historical research

The present study answers many questions but also raises ideas for future research. Some are highlighted here, particularly those which might inform discussion on service development and provision. To underpin this, it is essential to ensure that the specialty is documented, that archives are not destroyed and that ‘witnesses’ are encouraged to record their experiences. The present study might encourage this history ‘out-reach’ work in addition to formal historical research.

Continuing a chronological over-view of the development of the specialty beyond 1989

Examining the development of services since 1989 would include studying the range, quantity, style and effectiveness of services and the responses, including of older people, health service professionals and policy makers, to them. This raises questions as to whether and how long-established attitudes have

continued to shape service development in the light of other societal changes, including equalities legislation, economic pressures, expectations of older people themselves, the changing roles of women and the effects of high-profile campaigning organisations such as the Alzheimer's Society. A drawback to investigating key aspects of the most recent years would be the need for FoI requests to obtain access to government archives, although the current move from the '30 year rule' to a '20 year rule' for access will assist with studies of this period.³⁴

Components of services

Detailed studies of many components of psychogeriatric services and clinical practices warrant historical investigation, some before 1989, some since and others covering both periods.

Long-stay care

The present study identified numerous historical uncertainties relating to long-stay care. Issues for investigation include: the process of closing psychiatric hospitals and creating alternative services; the pros and cons of segregated and integrated care homes; how the funding, type, quality and quantity of institutional care impacted on people requiring it and on their families; monitoring and maintaining standards; and how, when and why older people were transferred *en masse* between facilities and the outcomes of those transfers.

Memory clinics and liaison psychiatry

From the mid-1980s, new service components, such as 'memory clinics' and liaison psychiatry – providing advice in the general hospital for physically unwell older people with co-existing psychiatric symptoms – developed in an un-coordinated way. Despite government recommendations for national services,³⁵ prioritisation, funding and adequacy of provision varied hugely

³⁴ TNA, 'Move to 20 years rule begins' <http://www.nationalarchives.gov.uk/news/797.htm> accessed 21.4.2013

³⁵ e.g. Department of Health, *National Service Framework for Older People* (London: DoH, 2001)

between localities. These themes are topical; understanding their development may have implications for commissioning services in 2014.

Multi-disciplinary interfaces

Psychogeriatrics has consistently taken multi-disciplinary approaches to clinical work. However, the present study suggests that involvement of nurses, psychologists, social workers, occupational therapists and other disciplines in service development and evaluation was infrequent at least until the 1980s. The relationships between primary and secondary care for older people and geriatrics and psychogeriatrics are also little researched and may shed further light on the development of the specialty.

Clinical and scientific research

The partial successes, frustrations and difficulties associated with attempting to prevent, cure or effectively palliate Alzheimer's and other dementias, have been challenging for researchers, clinicians, patients, carers, economists and politicians and require historical investigation. This might include a specific study of research undertaken in Newcastle upon Tyne. The Newcastle theme is pressing, since some of the participants from the 1950s and 1960s have now reached advanced ages, but can still be interviewed. Roth died in 2006 but his leadership there (1956-77) is well remembered.³⁶ Significant research continued there after 1977, notably on Lewy Body dementia and the neurochemistry of Alzheimer's disease.

Political and economic analyses

An in-depth study of government policy-making using National Archives and FoI requests, might assist in understanding the motivation and fluctuating activity of successive governments concerning establishing services to meet the health and social care needs of older people.

Consistent under-provision of old age services suggests the need for a comprehensive, including numerical, analysis of the resources provided,

³⁶ Garry Blessed, discussion, 2012

relative to other health service demands and demographic and epidemiological factors. This could be undertaken collaboratively between historians of health service policy and economists.

The Sans Everything, Ely Hospital and other inquiries

Despite the closure of long-stay psychiatric hospitals, NHS and social care scandals continue.³⁷ Successive inquiries make almost identical recommendations, suggesting earlier lack of implementation or ineffectiveness, and reinforcing the suspicion that little has changed fundamentally in providing for vulnerable older people. A detailed historical analysis of the *Sans Everything*, Ely Hospital and other inquiries and their impact on quality of care is indicated.

Last word: looking back, looking forward

Reflecting on the past and looking to the future, in the opinion of Sabina Burza, who completed her training as an old age psychiatrist in 2013, there is realistic optimism among the next generation of professional leaders:

Without the inspirational work of the visionaries of psychogeriatrics, the development of the existing myriad of innovative services for older people would not have been possible. Inevitably there continue to be challenges ... such as inequality of funding and ageist attitudes. However, with the dedication and enthusiasm of future generations of healthcare workers committed to serving this population, these will continue to be challenged, inspired by patients, carers and colleagues.³⁸

³⁷ e.g. *Care and Compassion: report of the health service ombudsman on ten investigations into NHS care of older people*. 2011 <http://www.ombudsman.org.uk/care-and-compassion> accessed 3.7.2011; Peter Wasson, *We've been listening, have you been learning?* (Patients Association, 2011) <http://patients-association.com/default.aspx?tabid=80&Id=23> accessed 21.10.2012

³⁸ Sabina Burza, correspondence, April 2013

Appendix

Copyright

I have so far been unable to obtain permission to reproduce the illustration of Lionel Cosin (Fig 6, page 117).

The picture accompanied the obituary of Lionel Cosin in the *BMJ*.¹

The artist signed his work 'Mikko'.

The original belongs to Ben Cosin, Lionel Cosin's son.

The author of the obituary has died.

The following approaches were made:

- a. The *BMJ* (bmj.permissions@bmjgroup.com) does not have records of sources of obituary illustration in 1994.
- b. The British Geriatrics Society: archivists and historians Mark Stewart and Michael Denham (committees@bgs.org.uk) were unable to give further guidance.
- c. The Cartoon Museum: curator Anita O'Brien (info@cartoonmuseum.org) advised that they were unable to identify 'Mikko' in their databases or directories of professional cartoonists.
- d. Neither Ben Cosin nor Pip Cosin (Lionel's daughter) was able to give further advice.

¹ Irvine, RE. 'LZ Cosin' *BMJ* (1994) 309: 189

Bibliography

Primary sources

Institutional archives

Bethlem-Maudsley Hospital, Bethlem Royal Hospital, Kent (BMHA)

General Purposes Sub-committee

Medical Committee

Rehabilitation Committee

Sub-committee to consider arrangements for the follow-up office

British Geriatrics Society, London (BGSA)

Lord Amulree's papers

At the time of research, many documents were only loosely categorised and were in open filing cabinets and on shelves.

British Medical Association, London (BMAA)

Committee on the Care and Treatment of the Elderly and Infirm

General Medical Services Committee

Geriatrics Joint Sub-committee

Medical Services Committee

Psychological Medicine Group

Greater Glasgow Archives, Glasgow

Barony Parochial Asylum, HB30/2/12A 19

Institute of Psychiatry, London

Felix Post, 'Marjory Warren Lecture' 1979, R16068

King's Fund Library, London (KFL)

Class number: QBFA

DHSS circulars

National Archives, Kew (TNA)

Cabinet papers

CAB 128/45	Cabinet conclusions, 1970
CAB 129/193	Cabinet memoranda, 1976
CAB 129/197/3	Public Expenditure to 1981-82
CAB 129/200/3	Expenditure on the National Health Service, 1978

Ministry of Housing and Local Government

HLG 118/2846	White Paper on elderly people, <i>Growing Older</i> , 1979-81
--------------	---

MoH/DHSS

MH 121/8	Royal Commission, Correspondence: Lord Percy, 1954-57
MH 55/2585	Staffing of mental hospitals, 1953-60
MH 133/497	Standing Mental Health Advisory Committee, minutes, 1949-50
MH 133/502	Standing Mental Health Advisory Committee, 1949-52
MH 150/449	Post-Ely Policy Working Party: proposals for minimum targets, 1969-72
MH 150/645	Hospital services for the elderly, scope of geriatric medicine, 1975-76
MH 150/812	Psychiatric hospital services, manpower planning, 1974-76
MH 154/11	Accommodation for the elderly, 1961-65
MH 154/511	Development of local health and welfare services, 1966-73
MH 154/675	Alcoholism, 1973-76
MH 154/935	White Paper "Better Services for the Mentally Ill", 1976-88
MH 154/953	Worcester Development Project, proposals for the siting of the senile dementia unit, 1972-76
MH 154/985	Provision of care and services for the elderly, 1976-77
MH 154/1066	Discussion document on the elderly, <i>A Happier Old Age</i> , 1977-78

MH 154/1068-70	Discussion document on the elderly, <i>A Happier Old Age</i> , 1978
MH 154/1328	Medical Manpower Steering Group, 1979-81
MH 154/1376	Policy on the transfer of patients from mental hospitals to community care, 1979-83
MH 154/1562	Consultative document on moving resources for care in England <i>Care in the Community</i> , 1982
MH 160/486	Provision of psychiatric services for the elderly, 1965-66
MH 166/135	NHS: local government reorganisation: comments on White Paper, 1971-72
MH 166/583	NHS capital investment, psychiatric and geriatric service, 1967-69

Prime Minister's Office

PREM 13/2803	Ill-treatment of elderly patients in certain NHS hospitals: enquiry into allegations, 1968-69
--------------	---

Penguin Books Archive, Bristol

Correspondence relating to Whitehead, *In the Service of Old Age*

Royal College of Nursing, Edinburgh (RCNA)

C305/	Annie Altschul's papers
RCN/15/7/	Society of Geriatric Nursing

Royal College of Physicians of London (RCPA)

MS4811-4814	RCP/RCPsych joint working party
-------------	---------------------------------

Royal College of Psychiatrists, London (RCPsychA)

BGS / RCPsych liaison group
 Council
 Geriatric Committee / Sub-committee
 Group for the Psychiatry of Old Age (GPOA)
 Group into Section, 1980-81
 Joint Committee on Higher Professional Training (JCHPT)
 Manpower Committee

Section for the Psychiatry of Old Age (SPOA)
Specialty Recognition, 1987-88

Wellcome Library, Archives and Manuscripts, London (WL)

WL/GC/244/2/19 Diana Gittins (Russell Barton interview)

WL/PP/DOL/A/1/12 Sir Richard Doll

WL/PP/RFK/C.8 Rudolf Freudenberg

Personal archives

Prof Tom Arie (TA)

Dr Peter Jefferys (PJ), Currently in my possession. All documents relate to the GPOA 1973-78. In 2013, plans are underway to expand the archives storage space at the RCPsych, giving the possibility of depositing them there long term.

Prof David Jolley, for copies of *SPOA Newsletters*, 1980-86

Dr Gordon Langley

Mrs Ida Lawrence

Dr Felix Post (FP), in possession of Julian Post.

Witness seminar

Guthrie Trust Witness Seminar 2008, *The Development of Old Age Psychiatry in Britain 1960-1989* ed. Claire Hilton (University of Glasgow, 2009)
www.gla.ac.uk/media/media_196526_en.pdf

Chair: Dr Claire Hilton

*Participants:*¹

Prof Tom Arie, b. Prague 1933, q. 1960, Oxford. Appointed consultant psychogeriatrician 1969, Goodmayes Hospital, Ilford, then professor, Department of Health Care of the Elderly, Nottingham, 1977

Dr Klaus Bergmann, b. Dresden 1930, q. Sheffield. Consultant psychogeriatrician 1966 in Brighton, then Newcastle upon Tyne 1969, then Bethlem Maudsley, London, 1978.

Dr (WD) Bill Boyd, q. 1954. Consultant psychogeriatrician, Edinburgh

Dr Colin Godber, b. 1940, q. 1964, Oxford and Middlesex Hospital. Appointed consultant psychogeriatrician, Southampton, 1973

Dr Nori Graham, q. 1961, Oxford and University College Hospital. Consultant psychogeriatrician, Royal Free Hospital, London

¹ 'Biographies of witnesses', 'Witness' 69-102; Hilton *et al.* 'A witness seminar'

Dr Peter Jefferys, b. 1944, q. 1969. Appointed consultant psychogeriatrician, Northwick Park Hospital, 1976

Prof David Jolley, b. Wolverhampton 1944, q. 1969, Guy's Hospital. Appointed consultant psychogeriatrician, Manchester, 1975, then Professor, University of Wolverhampton

Dr Gordon Langley, appointed consultant psychogeriatrician, Exe Vale Hospital, Exminster, 1965

Prof Brice Pitt, q. Guy's Hospital. Appointed consultant psychogeriatrician, Claybury Hospital 1966, then in East London, then Professor of Psychogeriatrics, St Mary's Hospital, London, 1986

Dr Ronald (Sam) Robinson, q. Queen's University, Belfast. Appointed consultant, Crichton Royal Hospital, Dumfries, 1958, then Edinburgh

Prof John Wattis, q. Liverpool. Consultant psychogeriatrician, Leeds then Huddersfield and visiting professor, University of Huddersfield, 2000

Prof James (Jimmy) Williamson, b. 1920, q. 1943, Glasgow. Consultant geriatrician from 1959, and Professor of Geriatric Medicine, Liverpool, 1973-76 and Edinburgh, 1976-86

Autobiographical information provided by people invited who could not attend

Dr Michael Denham, appointed consultant geriatrician, Northwick Park Hospital, Harrow, 1973

Prof Robin Jacoby, consultant psychogeriatrician, Bethlem-Maudsley 1983-94, then Professor, University of Oxford

Dr Michael (DMD) White, consultant psychogeriatrician Aylesbury 1970-77, then Hereford

Individual oral history interviews

Interviewed by author

The tapes and transcripts are currently in my possession. I plan to deposit them at the RCPsych when their new archive facilities are available.

Prof Tom Arie, 2004

Dr Klaus Bergmann, 2004

Dr Michael Denham, 2007

Prof Robin Jacoby, 2004

Prof Raymond Levy, 2009 (second interview) Psychogeriatrician, Bethlem-Maudsley Hospital and Institute of Psychiatry, London

Prof Brice Pitt, 2004, 2006

Ms Sara Turner, 2010. Psychologist for older people, South London

The Oral History of Geriatrics as a Medical Speciality

British Library Sound Archives (BLSA C512) 1991

Project leader: Margot Jefferys

Interviews referred to in this thesis:

Prof George Adams, interviewer Anthea Holmes

Prof Tom Arie, interviewer Hazel Houghton

Dr Lionel Cosin, interviewer Margot Jefferys

Sir George Godber, interviewer Margot Jefferys

Prof W Alwyn Lishman, interviewer Margot Jefferys

Dr Eric Morton, interviewer Hazel Houghton

Ms Doreen Norton, interviewer Margot Jefferys

Prof Brice Pitt, interviewer Margot Jefferys

Dr Felix Post, interviewer Margot Jefferys

Rt Hon. Enoch Powell, interviewer Margot Jefferys

Sir Kenneth Robinson, interviewer Margot Jefferys

Prof Sir Martin Roth, interviewer Margot Jefferys

Other interviews

Prof Tom Arie, interviewer Elaine Murphy, 'A conversation with Tom Arie'
International Journal of Geriatric Psychiatry (1996) 11: 671-679

Dr Russell Barton, interviewer Diana Gittins (1995) GC/244/2/19 transcript,
Wellcome Library

Dr Felix Post, interviewer Brian Barraclough (1988) Edited transcript, 157-177.
In: *Talking about Psychiatry* ed. Greg Wilkinson (London: Gaskell, 1993)

Dr Felix Post, interviewer Conrad Woods (1996) Imperial War Museum, Tape
16642

Dr Felix Post, interviewer unknown (c.1996) (in the possession of Julian Post)

Government publications

Audit Commission, *Making a Reality of Community Care* (London: HMSO,
1986)

Beveridge, William. *Social Insurance and Allied Services* Cmd. 6404 (London:
HMSO, 1942)

Black Report, see DHSS, *Inequalities in Health*

Boucher Report, see Ministry of Health, *Survey of Services*

Committee on Local Authority and Allied Personal Social Services (Seebohm Report) Cmnd. 3703 (London: HMSO, 1968)

Committee on the Economic and Financial Problems of the Provision for Old Age (Phillips Report) Cmd. 9333 (London: HMSO, 1954)

Department of Health, *National Service Framework for Older People* (London: DoH, 2001)

DHSS, *Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and other Irregularities at the Ely Hospital, Cardiff* Cmnd. 3975 (London: HMSO, 1969)

DHSS, *On the State of the Public Health: the annual report of the chief medical officer of the Department of Health and Social Security for the year 1970* (London: HMSO, 1970)

DHSS, *Psycho-Geriatric Assessment Units* HM (70)11 (London: HMSO, 1970)

DHSS, *Hospital Services for the Mentally Ill* HM (71)97 (London: HMSO, 1971)

DHSS, *National Health Service Reorganisation (England)* Cmnd. 5055 (London: HMSO, 1972)

DHSS, *Services for Mental Illness Related to Old Age* HM (72)71 (London: HMSO, 1972)

DHSS, *Department of Psychiatry (Mental Illness) for a District General Hospital* (London: HMSO, 1973)

DHSS, *The Facilities and Services of Psychiatric Hospitals in England and Wales 1971* (London: HMSO, 1973)

DHSS, *Community Hospitals: their role and development in the National Health Service* (DHSS, 1974)

DHSS, *Providing a Comprehensive District Psychiatric Service for the Adult Mentally Ill* (London: HMSO, 1974)

DHSS, *Third Report of the Joint Working Party on the Organisation of Medical Work in Hospitals* (Third Cogwheel Report) (London: HMSO, 1974)

DHSS, *The Facilities and Services of Psychiatric Hospitals in England and Wales 1972* (London: HMSO, 1974)

DHSS, *Better Services for the Mentally Ill* Cmnd. 6233 (London: HMSO, 1975)

DHSS, *Priorities for Health and Personal Social Services in England: a consultative document* (London: HMSO, 1976)

DHSS, *Psychiatric Hospitals and Units in England: in patient statistics from the mental health enquiry for the year 1973* (London: HMSO, 1976)

DHSS, *Sharing Resources for Health in England: report of the Resource Allocation Working Party* (London: HMSO, 1976)

DHSS, *The Facilities and Services of Psychiatric Hospitals in England and Wales 1973* (London: HMSO, 1976)

DHSS, *A Happier Old Age: a discussion document on elderly people in our society* (London: HMSO, 1978)

DHSS, *Hospital In-patient Enquiry Main Tables 1978* (London: HMSO, 1978)

DHSS, *Medical Manpower – the next 20 years* (London: HMSO, 1978)

DHSS, *Patients First: Consultative paper on the structure and management of the NHS in England and Wales* (London: HMSO, 1979)

DHSS, *Inequalities in Health: report of a research working group* (Black Report) (DHSS, 1980); In: *Inequalities in Health: the Black Report* ed. Peter Townsend, Nick Davidson (Harmondsworth: Penguin Books, 1992)

DHSS, *Organisational and Management Problems of Mental Illness Hospitals: report of a working group* (Nodder Report) (London: DHSS, 1980)

DHSS, *Care in Action: a handbook of policies and priorities for the Health and Personal Social Services in England* (London: HMSO, 1981)

DHSS, *Care in the Community: a consultative document on moving resources for care in England* (1981)

DHSS, *Growing Older* Cmnd. 8173 (London: HMSO, 1981)

DHSS, *District Services for Mental Illness in Old Age Demonstrating Development, 1983: proposals submitted by RHAs* (London: DHSS, 1983)

DHSS, *Health Care and its Costs: the development of the National Health Service in England* (London: HMSO, 1983)

DHSS, *In-Patient Statistics from the Mental Health Enquiry for England 1981* (London: HMSO, 1984)

DHSS, *Social Security Statistics 1984* (HMSO: Government Statistical Services, 1984)

DHSS, *Hospital Statistics - form SH3 'National and Regional Summaries for 1986' Prepared by Government Statistical Services* (1987)

DHSS, *Review of the Resource Allocation Working Party Formula: final report by the NHS Management Board* (London: DHSS, 1988)

Gray, Archibald. Topping, Andrew. *Hospital Survey: the hospital services of London and the surrounding area* (London: HMSO, 1945)

Griffiths, Roy. *National Health Service Management Inquiry Report* (Griffiths Report on the NHS) (London: HMSO, 1983)

Griffiths, Roy. *Community Care: agenda for action* (Griffiths Report) (London: HMSO, 1988)

Guillebaud Report, see Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service*

Hansard: The Official Recording of the UK Parliament (see Websites)

Health Advisory Service, *The Rising Tide: developing services for mental illness in old age* (Surrey: NHS HAS, 1982)

House of Commons Social Services Committee, *First report: Session 1983-4: Griffiths NHS Management Inquiry Report* (London: HMSO, 1984)

House of Commons Social Services Select Committee, *Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People* Vol. 1 (London: HMSO, 1985)

Mackintosh Report, see Ministry of Health, *Report of the Committee on Social Workers in the Mental Health Services*

Mental Deficiency Committee (Wood Report) (London: HMSO, 1929)

Ministry of Health, *National Health Service Act 1946: provisions relating to the mental health services* (London: HMSO, 1948)

Ministry of Health, *Care of the Aged Suffering from Mental Infirmity* HMC(50)25 (1950)

Ministry of Health, *Treatment of the Elderly Chronic Sick* HMC(50)38 (1950)

Ministry of Health, *Report for the Year Ended 31st March 1950* Cmd. 8342 (London: HMSO, 1951)

Ministry of Health, *Report of the Committee on Social Workers in the Mental Health Services* Cmd. 8260 (Mackintosh Report) (London: HMSO, 1951)

Ministry of Health, *On the State of the Public Health, being the Annual Report of the Chief Medical Officer for the year 1950. Part 2.* Cmd. 8582 (London: HMSO, 1952)

Ministry of Health, *Report of the Committee of Enquiry into the Cost of the National Health Service* Cmd. 9663 (Guillebaud Report) (London: HMSO, 1956)

Ministry of Health, *Geriatric Services and the Care of the Chronic Sick* HM(57)86 (London: MoH, 1957)

Ministry of Health, *Survey of Services Available to the Chronic Sick and Elderly 1954-55* (Boucher Report) (London: HMSO, 1957)

Ministry of Health, *Report for the Year 1960. Part II: on the state of the public health* Cmd. 1550 (London: HMSO, 1961)

Ministry of Health, *A Hospital Plan for England and Wales* Cmd. 1604 (London: HMSO, 1962)

Ministry of Health, *Health and Welfare: the development of community care: plans for the health and welfare services of the local authorities in England and Wales* Cmd. 1973 (London: HMSO, 1963)

Ministry of Health, *Care of the Elderly in Hospitals and Residential Homes* HM(65)77 (London: HMSO, 1965)

Ministry of Health, *Health and Welfare: the development of community care* (Revision to 1975-6) (London: HMSO, 1966)

Ministry of Health, *First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals* (Cogwheel Report) (London: HMSO, 1967)

Ministry of Health, *The Activities of Psychiatric Hospitals: a regional comparison. Mental hospitals and units 1964* (Statistical Report Series No. 3) (London: HMSO, 1968)

Ministry of Health, Central Health Services Council, *Psychiatric Nursing Today and Tomorrow: report of the Joint Sub-committee of the Standing Mental Health and the Standing Nursing Advisory Committees* (London: HMSO, 1968)

Ministry of Health and Department of Health for Scotland, *A National Health Service* Cmd. 6502 (London: HMSO, 1944)

Ministry of Health and Department of Health for Scotland, *Report of the Inter-Departmental Committee on Medical Schools* (Goodenough Report) (London: HMSO, 1944)

Ministry of Health and Scottish Home and Health Department, *Report of the Committee on Senior Nursing Staff Structure* (Salmon Report) (London: HMSO, 1966)

Ministry of Health and Social Services, *Geriatric and Psychiatric Services for the Elderly* (Belfast: HMSO, 1970)

National Health Service, *Findings and Recommendations Following Enquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals* Cmd. 3687 (London: HMSO, 1968)

National Health Service, *Annual Report of the Hospital Advisory Service to the Secretary of State for Social Services and Secretary of State for Wales for the year 1974* (London: HMSO, 1974)

Nodder Report, see DHSS, *Organisational and Management Problems of Mental Illness Hospitals*

North Western Regional Health Authority, *On the Transfer of Patients from Fairfield Hospital to Rossendale Hospital* (NWRHA, 1975)

Office for National Statistics, 'Decennial Life Tables, No.16 (2000-2002)' *Population Trends* (2009) 136: 3

Office of Population Census and Surveys, *Census Guide 1: Britain's elderly population 1981 Census* (London: HMSO, 1984)

Percy Report, see *Report of Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*

Phillips Report, see Committee on the Economic and Financial Problems of the Provision for Old Age

Registrar General's Statistical Review of England and Wales for the Year 1960: supplement on mental health (London: HMSO, 1964)

Report of the Royal Commission on Lunacy and Mental Disorders, Cmd. 2700 (London: HMSO, 1926)

Report of the Royal Commission on Population, Cmd. 7695 (London: HMSO, 1949)

Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Report) Cmd. 169 (London: HMSO, 1957)

Report of the Royal Commission on the National Health Service (Merrison Report) Cmd. 7615 (London: HMSO, 1979)

Salmon Report, see Ministry of Health and Scottish Home and Health Department, *Report of the Committee on Senior Nursing Staff Structure*

Scottish Home and Health Department, Scottish Health Services Council, *Services for the Elderly with Mental Disorder* (Millar Report) (Edinburgh: HMSO, 1970)

Seebom Report, see Committee on Local Authority and Allied Personal Social Services

Wood Report, see *Mental Deficiency Committee*

UK Acts of Parliament and other legislation

Abortion Act 1967, chapter 87

Chronically Sick and Disabled Person's Act 1970, chapter 44

Equality Act 2010, chapter 15

Local Government Act 1929, 19 & 20 Geo 5, chapter 17

Medical Act 1956, 4 and 5 Eliz 2, chapter 76

Mental Health Act 1959, 7 and 8 Eliz 2, chapter 72

Mental Treatment Act 1930, 20 and 21 Geo 5, chapter 23

National Health Service Act 1946, 9 and 10 Geo 6, chapter 81

National Health Service and Community Care Act 1990, chapter 19

Old Age and Widows' Pension Act 1940, 3 and 4 Geo 6, chapter 13

Race Relations Act 1965, chapter 73

Sex Discrimination Act 1975, chapter 65

Sexual Offences Act 1967, chapter 60

Suicide Act 1961, 9 and 10 Eliz 2, chapter 60

Institutional publications

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, DSM-II* (Washington DC: APA, 1968)

Association of Psychiatric Social Workers, *Relationship in Casework* (London: APSW, c.1963)

Bristol Local Medical Committee, *Report on the Treatment and Care of the Elderly Chronic Sick in Bristol* (Bristol: Bristol LMC, 1953)

British Geriatrics Society / Royal College of Psychiatrists, 'Joint report of the on matters relating to the care of psycho-geriatric patients' *News and Notes* (RCPsych) (Aug. 1973) 2-3

British Geriatrics Society / Royal College of Psychiatrists / Royal College of Nursing, *Improving Care of Elderly People in Hospital* (London: RCN, 1987)

- British Medical Association, Committee on Mental Health, *Report* (London: BMA, 1941)
- British Medical Association, *The Care and Treatment of the Elderly and Infirm* (London: BMA, 1947)
- British Medical Association, *When You are Old* (London: BMA, 1949)
- British Medical Association, *Report of the Advisory Panel of the BMA on Health Services Financing* (London: BMA, 1970)
- British Medical Association, Board of Science and Education, *All our Tomorrows: growing old in Britain* (London: BMA, 1986)
- Economist Intelligence Unit, *A New Vision for Old Age: rethinking health policy for Europe's ageing society* (London: The Economist, 2012)
- Faculty of the Psychiatry of Old Age, *In-patient Care for Older People within Mental Health Services* (London: RCPsych, 2011)
- General Medical Council Education Committee, *Recommendations on Basic Medical Education - issued in pursuance of Section 15 of the Medical Act 1978* (London: GMC, 1980)
- Group for the Psychiatry of Old Age, 'Memorandum on residential homes for the elderly mentally infirm' *News and Notes* (RCPsych) (Sept. 1976) 10-12
- Group for the Psychiatry of Old Age, 'Memorandum on nurse staffing needs for the hospital service for the elderly mentally ill' *Psychiatric Bulletin* (1978) 2: 4-5
- King's Fund Centre, *Living Well into Old Age: applying principles of good practice to services for people with dementia* (London: King's Fund Centre, 1986)
- Mass Observation, 'Old Age' *Mass Observation Bulletin* (Oct-Nov. 1948) 21: 1-4
- Medical Research Council, *Senile and Pre-senile Dementias: a report of the MRC subcommittee* (compiled by W Alwyn Lishman) (London: MRC, 1977)
- Medical Research Council, *The Health of the UK's Elderly People* (London: MRC, 1994)
- MIND, *Now tell us how to solve the Psychogeriatric Problem of the Psychiatric Hospitals* (London: MIND, 1972)
- MIND, *Psychogeriatric Services – the questions answered* (London: MIND, 1973)
- MIND, *Mental Health of Elderly People – MIND's response to the DHSS discussion paper 'A Happier Old Age'* (London: MIND, 1979)
- National Group of Geriatric Almoners, *Almoner* (1962) 14: 529; (1962) 15: 188; (1963) 16: 48
- National Old People's Welfare Council, *Notes on Mental Frailty in the Elderly* (London: National Council of Social Services, 1958)
- National Demonstration Services in Rehabilitation, 'Community Care: agenda for action: a response' *Psychiatric Bulletin* (1989) 13: 538-541

Organisation for Economic Co-operation and Development, *Public Expenditure on Health* (OECD Studies on Resource Allocation no. 4) (Paris: OECD, 1977)

Political and Economic Planning, *Population Policy in Great Britain* (London: PEP, 1948)

Rowntree, B Seebohm. (Chair) *Old People: report of a survey committee on the problems of ageing and the care of old people* (London: Nuffield Foundation, 1947)

Royal College of General Practitioners, *Education in Psychology and Psychiatry* (London: RCGP, 1967)

Royal College of Physicians, 'Medical Care of the Elderly' *Lancet* (1977) i: 1092-1095

Royal College of Physicians / Royal College of Psychiatrists, *Care of Elderly People with Mental Illness: specialist services and medical training* (London: RCP / RCPsych, 1989)

Royal College of Psychiatrists, 'Memorandum on the National Health Service Reorganisation consultative document' *British Journal of Psychiatry* Supplement (Dec. 1971) 2-3

Royal College of Psychiatrists, 'Memorandum on *Hospital Services for the Mentally Ill* (HM(71)97)' *News and Notes* (RCPsych) (July 1972) 3-4

Royal College of Psychiatrists, 'Memorandum of evidence to the Royal Commission on the National Health Service' *News and Notes* (RCPsych) (April 1977) 1-5

Royal College of Psychiatrists, 'Comment on the consultative documents: *Priorities for Health and Personal Services in England and Joint Care Planning: Health and Local Authorities*' *News and Notes* (RCPsych) (Aug. 1976) 3-9

Royal College of Psychiatrists, 'A Happier Old Age: the College's comments' *Psychiatric Bulletin* (1979) 3: 85-87

Royal College of Psychiatrists, 'Comments on the Griffiths Report: *Community Care: agenda for action*' *Psychiatric Bulletin* (1988) 12: 385-388

United Nations, *Vienna International Plan of Action on Aging* (New York: UN, 1983)

World Health Organisation, *Mental Health Problems of Aging and the Aged* (Geneva: WHO, 1959)

World Health Organisation, *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death* Eighth Revision (Geneva: WHO, 1967-69)

World Health Organisation, *Psychogeriatrics* (Geneva: WHO, 1972)

World Health Organisation, *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death* Ninth Revision (Geneva: WHO, 1977-78)

Conference proceedings and papers

Brain Failure in Old Age: proceedings of a conference held in December 1975 in Jersey, Channel Islands ed. William Ferguson Anderson, JR. Carlton-Ashton
Age and Ageing (1977) Supplement

Clarke, M. 'Organising nursing services' 108-110

Arie, Tom. In: 'Discussion' 115

Current Achievements in Geriatrics: papers read at a conference on medical and surgical aspects of ageing held in Glasgow under the auspices of the Glasgow Postgraduate Medical Board, November 20-23rd 1963 ed. William Ferguson Anderson, Bernard Isaacs. (London: Cassell, 1964)

Davidson, Robert. 'The significance of paranoia' 184-189

Emerging Patterns for the Mental Health Services and the Public: proceedings of a conference at Church House Westminster, 9-10 March 1961 (London: NAMH, 1961)

Powell, Enoch. 'Opening speech' ('Water tower') 5-10

International Association of Gerontology, *Third Congress: old age in the modern world* (Edinburgh: Livingstone, 1955)

Ginzberg, Raphael. 'Psychiatric and psychological techniques in the treatment and management of elderly psychotics' 457-462

International Association of Gerontology, *Fourth Congress* (Fidenza: Tito Mattioli, 1957)

Abel-Smith, Brian. 'The cost of the support of the aged' 11-16

Post, Felix. 'The significance of affective symptoms in old age' 227-230

International Association of Gerontology, *Aspects of Geriatric Psychiatry, Haematology, Nutrition and Cancer in Old Age* (September 13-16th 1961) ed. Eluned Woodford-Williams, A Norman Exton-Smith (Basle: Karger, 1962)

Robinson, Ronald (Sam). 'The practice of a psychiatric geriatric unit' 1-19

Mental Health and Social Work: report of a residential seminar held at Uplands, Four Ashes, High Wycombe, Bucks, England, in September 1961 ed. Elizabeth Irvine (London: Association of Social Workers, 1963)

Simson, Erna. 'The mentally disturbed aged' 13-17

Psychiatric Hospital Care: a symposium ed. Hugh Freeman (London: Baillière, Tindall and Cassell, 1965)

Townsend, Peter. 'A national survey of old people in psychiatric and non psychiatric hospitals, residential homes, and nursing homes' 223-232

Recent Developments in Psychogeriatrics: a symposium ed. David Kay, Alexander Walk, (London: RMPA, 1971)

Donovan, J. Williams, I. Wilson, T. 'A fully integrated psychogeriatric service' 113-125

Brothwood, John. 'The organisation and development of services for the aged with special reference to the mentally ill' 99-112

Royal Medico-Psychological Association, 104th Annual Meeting, September 1945, *Journal of Mental Science* (1946) 92: 146-194 and Supplement 14-16

Eysenck, Margaret. 'The psychological aspects of ageing and senility' 171-181

Goldschmidt, Helen. 'Social aspects of ageing and senility' 182-194

Lewis, Aubrey. 'Ageing and senility: a major problem of psychiatry' 150-170

McCalman, Douglas. In: 'General discussion' 193

Pool, Arthur. In: 'General discussion' 193

Russell, Ivison. In: 'General discussion' 194

World Psychiatric Association, *Psychiatric Disorders in the Aged* (Manchester: Geigy, 1965)

Post, Felix. 'Diagnosis and management of paranoid syndromes' 108-120

Robinson, Ronald (Sam). 'The organisation of a diagnostic and treatment unit for the aged in a mental hospital' 186-205

Grad, Jacqueline. Sainsbury, Peter. 'An evaluation of the effects of caring for the aged at home' 225-236

Corsellis, JAN (Nick). 'Cerebral degeneration and the mental disorders of later life' 292-307

Books, journals and newspapers, before 1935

Alzheimer, Alois. 'Über eigenartige Krankheitsfälle des späteren Alters' (1911) Translated into English; 'On certain peculiar diseases of old age' *History of Psychiatry* (1991) 2: 74-101

Anon. 'Death in Withington workhouse: inquiry by Guardians asked for' *Guardian*, 28.6.1913, 5

Anon. 'Aged woman's murder of her husband' *Times*, 8.7.1914, 4

Anon. 'Nursing home shortcomings: Committee's proposals: registration and inspection' *Guardian*, 20.7.1926, 12

Anstie, Francis. 'On certain nervous affections of old persons' *Journal of Mental Science* (1870) 16: 31-41

Clouston, Thomas. *Clinical Lectures on Mental Diseases* (London: J and A Churchill, 1887)

Day, George. *A Practical Treatise on the Domestic Management and Most Important Diseases of Advanced Life* (London: T and W Boone, 1849)

Freud, Sigmund. 'On psychotherapy' (1905 [1904]) 255-268. In: *The Standard Edition of the Complete Psychological Works of Sigmund Freud* tr. ed. James Strachey, Vol. vii (London: Hogarth Press, 1953)

Kraepelin, Emil. *Lectures on Clinical Psychiatry* (1901) ed. Thomas Johnstone (London: Baillière, Tindall and Cox, 1904)

Kraepelin, Emil. *Clinical Psychiatry: a text book for students and physicians*. Abstracted and adapted from the seventh German edition of Kraepelin's *Lehrbuch der Psychiatrie* by A Ross Diefendorf, revised (London: Macmillan Company, 1918)

Smith, Hubert Llewellyn. *The New Survey of London Life and Labour* Vol. 3 (London: PS King and Son, 1932)

Thewlis, Malford. *Geriatrics: a treatise on senile conditions, diseases of advanced life, and care of the aged* (St Louis: CV Mosby, 1919)

Books, chapters and pamphlets

Ackner, Brian. (ed.) *Handbook for Psychiatric Nurses* (London: Baillière, Tindall and Cox, 1964)

Agate, John. 'Hospitals and community care' 30-39. In: John Agate, Michael Meacher, *The Care of the Old* (London: Fabian Society, 1969)

Altschul, Annie. *Aids to Psychiatric Nursing* (London: Baillière, Tindall and Cox, 1957)

Altschul, Annie. *Psychiatric Nursing* (London: Baillière, Tindall and Cassell, 1968)

Altschul, Annie. Simpson, Ruth. *Psychiatric Nursing* (London: Baillière Tindall, 1977)

Appleby, John. *Spending on Health and Social Care over the next 50 years: why think long term?* (London: King's Fund, 2013)

Arie, Tom. 'Enough knowledge to be out of danger?' 2-4. In: *Recent Advances in Psychogeriatrics* 1. ed. Arie

Arie, Tom. (ed.) *Recent Advances in Psychogeriatrics* (No. 1) (Edinburgh: Churchill Livingstone, 1985)

Arie, Tom. (ed.) *Recent Advances in Psychogeriatrics* (No. 2) (Edinburgh: Churchill Livingstone, 1992)

- Arie, Tom. Isaacs, Anthony. 'The development of psychiatric services for the elderly in Britain' 241-261. In: *Studies in Geriatric Psychiatry* ed. Anthony Isaacs, Felix Post (Chichester: John Wiley and Sons, 1978)
- Arie, Tom. Jones, RG. Smith, CW. 'The educational potential of old age psychiatry services' 196-206. In: *Recent Advances in Psychogeriatrics* 1. ed. Arie
- Ashdown, Margaret. Brown, S Clement. *Social Service and Mental Health: an essay on psychiatric social workers* (London: Routledge and Kegan Paul, 1953)
- Bajekal, M. *Health Survey for England 2000: care homes and their residents* (London: TSO, 2002)
- Baker, Alex. (ed.) *Comprehensive Psychiatric Care* (Oxford: Blackwell Scientific Publications, 1976)
- Baker, Alex. Clark, Mollie. 'Mental illness in the elderly' 270-287. In: *Comprehensive Psychiatric Care* ed. Baker
- Barton, Russell. 'Foreword' 9-10. In: Whitehead, *Service of Old Age*
- Barton, Russell. *Institutional Neurosis* (Bristol: John Wright and Sons Ltd, 1976)
- Batchelor, Ivor. *Policies for a crisis? Some aspects of the DHSS policies for the care of the aged: a commentary* (London: NPHT, 1984)
- Bernard, Miriam. (ed.) *Developing Services for Elderly Mentally Infirm People: responses to the 'Rising Tide' initiative* (Keele: Beth Johnson Foundation Publications, 1987)
- Blacker, Carlos. Gore, A. (ed.) *Statistical Triennial Report 1949-1951* (London: Bethlem Royal Hospital and Maudsley Hospital, 1955)
- Breiger, E. *After-care and Rehabilitation* (Cambridge: Pendragon Press, 1937)
- Brocklehurst, John. *The Geriatric Day Hospital* (London: King Edward's Hospital Fund, 1970)
- Brocklehurst, John. Tucker, J. *Progress in Geriatric Day Care* (London: King Edward's Hospital Fund for London, 1980)
- Bromley, Dennis. *The Psychology of Human Ageing* (Harmondsworth: Penguin Books, 1967 and 1974)
- Brooke, Eileen. *A Cohort Study of Patients First Admitted to Mental Hospitals in 1954 and 1955* (London: HMSO, 1963)
- Cawley, Robert. McKeown, Thomas. 'Services for the mentally ill in a balanced hospital community' 134-155. In: *Trends in the Mental Health Services* ed. Hugh Freeman, James Farndale (Oxford: Pergamon Press, 1963)
- Collins, Joan. *Social Casework in a General Medical Practice* (London: Pitman Medical, 1965)
- Coni, Nicholas. Davison, William. Webster, Stephen. *Ageing: the facts* (Oxford: OUP, 1984)
- Conybeare, John. (ed.) *Textbook of Medicine* (Edinburgh: Livingstone, 1949)

- Cooper, David. 'Introduction' vii-ix. In: Michal Foucault, *Madness and Civilisation* (Oxford: Routledge, 1989)
- Copeland, John. Abou-Saleh, Mohammed. Blazer, Dan. (ed.) *Principles and Practice of Geriatric Psychiatry* (Chichester: John Wiley and Sons, 2002)
- Corsellis, JAN (Nick). *Mental Illness and the Ageing Brain* (London: OUP, 1962)
- Curran, Desmond. Guttman, Eric. *Psychological Medicine: a short introduction to psychiatry* (Edinburgh: E and S Livingstone, 1949)
- de Beauvoir, Simone. *Old Age*, tr. Patrick O'Brian (Harmondsworth: Penguin Books, 1977)
- Dick, Donald. 'The Rising Tide Initiative' 13-18. In: *Developing Services for Elderly Mentally Infirm People: responses to the 'Rising Tide' initiative* ed. Bernard
- Enoch, M David. Howells, John. *The Organisation of Psychogeriatrics* (Ipswich: SCP, 1971)
- Erikson, Erik. *Identity and the Life Cycle* (New York: International Universities Press, 1959)
- Evans, Neil. Kendall, Ian. Lovelock, Robin. Powell, Jackie. *Something to Look Forward To - an evaluation of a travelling day hospital for elderly mentally ill people* (Social Services Research and Intelligence Unit, Portsmouth 1986)
- Farndale, James. *The Day Hospital Movement in Great Britain* (Oxford: Pergamon Press, 1961)
- Feil, Naomi. *Validation: the Feil method* (Cleveland, OH: Edward Feil Productions, 1982)
- Felstein, Ivor. *Later Life: geriatrics today and tomorrow* (Harmondsworth: Penguin Books, 1969)
- Fenton, Louisa. 'They can not defend themselves' 31-37. In: Robb, *Sans Everything*
- Finch, Jenny. *Evaluating Mental Health Services for Older People* (Oxford: Radcliffe Publishing Ltd, 2004)
- Forsythe, Elizabeth. *Living with Multiple Sclerosis* (London: Faber, 1979)
- Freeman, Hugh. Farndale, James. (ed.) *Trends in the Mental Health Services* (Oxford: Pergamon Press, 1963)
- Gilleard, Chris. *Living with Dementia: community care of the elderly mentally infirm* (London: Croom Helm, 1984)
- Goffman, Erving. *Asylums: essays on the social situation of mental patients and other inmates* (New York: Anchor Books, 1961)
- Goffman, Erving. *Stigma: notes on the management of spoiled identity* (New York: Simon and Schuster, 1963)
- Goldberg, David. Huxley, Peter. *Mental Illness in the Community: the pathway to psychiatric care* (London: Tavistock, 1980)

- Goldberg, E Matilda. *Welfare in the Community* (London: National Council of Social Service, 1966)
- Hays, Peter. *New Horizons in Psychiatry* (Harmondsworth: Penguin Books, 1964)
- Hewitt, P. *Age Concern on Pensioner Incomes* (London: Age Concern, 1974)
- Hunter, Donald. (ed.) *Price's Textbook of the Practice of Medicine* (Oxford: OUP, 1956)
- Jefferys, Peter. Papp, Bob. Barrett, Sue. Jennings, Rosemary. Savage, Jane. 'The Herga Centre – a NHS run day centre for confused elderly people' 1-9. In: *Approaches to Day Care for Elderly People who are Mentally Infirm* (MIND, 1979)
- Jolley, David. Arie, Tom. 'Developments in psychogeriatric services' 117-135. In: *Recent Advances in Psychogeriatrics* 2. ed. Arie
- Kaplan, Oscar. (ed.) *Mental Disorders in Late Life* (Stanford: Stanford University Press, 1945 and 1956)
- Laing, RD. *The Divided Self: a study of sanity and madness* (London: Tavistock Publications, 1960)
- Laing, RD. Esterson, Aaron. *Sanity, Madness and the Family* (London: Penguin Books, 1964)
- Lewis, Aubrey, 'Introduction' 1-5. In: *Psychiatric Diagnosis in New York and London: a Comparative Study of Mental Hospital Admissions* ed. JE Cooper, RE Kendell, BJ Gurland, L Sharpe, JRM Copeland, R Simon (London: OUP, 1972)
- Mace, Nancy. Rabins, Peter with Beverley Castleton, Christopher Cloke, Evelyn McEwen, *The 36-hour Day: caring at home for confused elderly people*. (London: Hodder and Stoughton with Age Concern, c1985. UK edition, adapted from US edition Baltimore: Johns Hopkins Press, 1981)
- Maltaverne, S. 'Local experiences in French psychogeriatrics' 36-42 In: *Mental Health and Aging: report on an informal consultation* (Geneva: WHO, 1993)
- Mapou, Robert. Spector, Jack. (ed.) *Clinical Neuropsychological Assessment: a cognitive approach* (New York: Plenum Press, 1995)
- Martin, Denis. *Adventure in Psychiatry* (Oxford: Bruno Cassirer, 1962)
- Mayer-Gross, Willy. Slater, Eliot. Roth, Martin. *Clinical Psychiatry* (London: Cassell and Co Ltd, 1960)
- McKeown, Thomas. *Medicine in Modern Society* (London: George Allen and Unwin, 1965)
- McNally, Richard. '£6 million: value for money?' 19-23. In: *Developing Services* ed. Bernard
- Meacher, Michael. *Taken for a Ride: Special residential homes for confused old people: a study of separation in social policy* (London: Longman, 1972)

- Minski, Louis. *A Practical Handbook of Psychiatry for Students and Nurses* (London: Heinemann Medical Books, 1946)
- Norman, Alison. *Mental Illness in Old Age: meeting the challenge* (London: CPA, 1982)
- Norton, Doreen. *Hospitals of the Long Stay Patient: a study of their practical nursing problems and solutions* (Oxford: Pergamon, 1967)
- Norton, Doreen. McLaren, Rhoda. Exton-Smith, A Norman. *An Investigation of Geriatric Nursing Problems in Hospital* (London: NCCOP, 1962)
- Osbaldeston, Michael. 'Nobody wants to know' 13-18. In: Robb, *Sans Everything*
- Pitt, Brice. *Psychogeriatrics: an introduction to the psychiatry of old age* (Edinburgh: Churchill Livingstone, 1974)
- Post, Felix. *The Significance of Affective Symptoms in Old Age: a follow up study of 100 patients* (London: OUP, 1962)
- Post, Felix. *The Clinical Psychiatry of Late Life* (London: Pergamon Press, 1965)
- Post, Felix. *Persistent Persecutory States of the Elderly* (Oxford: Pergamon Press, 1966)
- Rees, Anthony. 'Problems of old age' 95-112. In: *The Social Workers: an introductory survey of social work today* (London: BBC, 1965)
- Robb, Barbara. (compiler) *Sans Everything: a case to answer* (London: Nelson, 1967)
- Roberts, Tecwyn. *A Handbook for Psychiatric Nurses* (Bristol: John Wright, 1971)
- Rooney, Paul. Matthews, Rowan. *Worcester Development Project: psychiatric provision – where do we go from here?* (London: DHSS, 1982)
- Rowntree, B Seebohm. *Poverty and Progress: a second social survey of York* (London: Longmans, Green and Co, 1941)
- Rudd, Thomas. *The Nursing of the Elderly Sick: a practical handbook of geriatric nursing* (London: Faber and Faber, 1964)
- Rudd, Thomas. *Human Relations in Old Age: a handbook for health visitors, social workers and others* (London: Faber and Faber, 1967)
- Rush, Joan. McAusland, Tom. *A Guide to Training Resources for Staff Working with "Confused" Elderly People* (London: Kings Fund Centre, 1982)
- Samson, Emily. *Old Age in the New World* (London: Pilot Press, 1944)
- Sargant, William. Slater, Eliot. *An Introduction to Physical Methods of Treatment in Psychiatry* (Edinburgh: Livingstone, 1944)
- Seldon, Arthur. Amulree, Lord. Lewis, Barbara. *The Aged and the Nation* (London: Liberal Publications Department, 1948)
- Shegog, RFA. (ed.) *The Impending Crisis of Old Age: a challenge to ingenuity* (Oxford: OUP, 1981)

- Sheldon, Joseph. *The Social Medicine of Old Age* (London: OUP, 1948)
- Sheldon, Joseph. *Report to the Birmingham Regional Hospital Board on its Geriatric Services* (Birmingham: RHB, 1961)
- Shepherd, Michael. Davies, David. (ed.) *Studies in Psychiatry – a survey of work carried out in the Department of Psychiatry of the Institute of Psychiatry under the chairmanship of Sir Aubrey Lewis 1945-66* (London: OUP, 1968)
- Stafford-Clark, David. *Psychiatry To-day* (Harmondsworth: Penguin Books, 1952)
- Szasz, Thomas. *The Myth of Mental Illness* (New York: Dell, c.1961)
- Taylor, Stephen. *Good General Practice* (London: OUP, 1954)
- Timms, Noel. *Psychiatric Social Work in Great Britain 1939-1962* (London: Routledge and Kegan Paul, 1964)
- Titmuss, Richard. *Poverty and Population: a factual study of contemporary social waste* (London: Macmillan and Co., 1938)
- Townsend, GWH. Exton-Smith, AN. Norman, The Lady. Post, Felix. Wilson, Tom. *Accommodation for the Mentally Infirm Aged: a report to the governors of the National Corporation for the Care of Old People by a committee appointed for this purpose* (London: NCCOP, 1963)
- Townsend, Peter. *The Last Refuge* (London: Routledge and Kegan Paul, 1962)
- Townsend, Peter. *The Family Life of Old People* (Harmondsworth: Penguin Books, 1963)
- Watts, Cuthbert. Watts, Beatrice. *Psychiatry in General Practice* (London: J and A Churchill, 1952)
- Wertheimer, Alison. *Mental Health of Elderly People: MIND's response to the DHSS discussion paper 'A Happier Old Age'* (London: MIND, 1979)
- Whitehead, Anthony (Tony). *In the Service of Old Age: the welfare of psychogeriatric patients* (Harmondsworth: Penguin Books, 1970)
- Whitehead, Tony. *A Ripe Old Age* (London: MIND, 1979)
- Whitehead, Margaret. *The Health Divide*, 221-437. In: *Inequalities* ed. Townsend and Davidson
- Worcester, Alfred. *Care of the Aged, the Dying and the Dead* (Springfield, Illinois: Thomas Books, 1935 and New York: Arno Press, 1977)
- Yellowlees, Henry. *To Define True Madness* (Harmondsworth: Penguin Books, 1953)

National and regional newspapers

- A mental hospital nurse, 'Patience and nurses' *Guardian*, 1.5.1957, 5
- Anon. "'Old People'" The Nuffield Foundation Report' *Guardian*, 15.1.1947, 4
- Anon. 'Don't mollycoddle old people' *Evening Standard*, 5.1.1948, 3

- Anon. 'Hospital beds shortage. Liverpool waiting list 12,622' *Times*, 29.12.1952, 2
- Anon. 'Helping the elderly and the confused to carry on: year's success at an Oxford Day Hospital' *Guardian*, 15.1.1954, 5
- Anon. 'Caring for the senile "Half-way homes"' *Guardian*, 13.6.1958, 14
- Anon. "'Hospital Slums" – Sir Keith' *Daily Telegraph*, 30.6.1973, 1
- Anon. 'Labour attack "savage" NHS cuts' *Times*, 29.1.1974, 7
- Anon. 'Aged "could be spared misery"' *Guardian*, 7.10.1974, 6
- Anon. 'NHS mental health care is criticised' *Times*, 24.2.1977, 3
- Anon. 'Caring questions' *Guardian*, 24.2.1989, 26
- Brindle, David. 'More psychiatrists urged for elderly' *Guardian*, 24.2.1989, 8
- Carling, Ernest Rock. 'The chronic sick: proper care for the aged and infirm, hospitals for protracted illness' *Times*, 25.11.1946, 5
- Geddes, Diana. 'Clash over closure plans for hospital' *Times*, 1.10.1976, 3
- Kellett, John. 'Resources for dementia' *Times*, 26.8.1982, 9
- Robertson, Kenneth. 'Old folks "certified insane" to find them beds' *Forward*, 25.3.1950, 1
- Roxan, David. 'Heartbreak Hospitals' *News of the World*, 20.8.1967, 7
- Roxan, David. "'I saw patients being treated like dogs"' *News of the World*, 27.9.1967, 7
- Smith, Tony. 'Who should be looking after grandpa?' *Times*, 21.2.1978, 18
- Strabolgi, Lord. Beaumont, Baroness. Heytesbury, Lord. Abel-Smith, Brian. Ardizzone, Edward. Harvey, Audrey. Hewetson, John. Robb, Barbara. Sargent, Bill. Woolgar, Daniel. 'Old people in mental hospitals' *Times*, 10.11.1965, 13
- Symon, Penny. 'Hospitals forced to turn away ambulance patients' *Times*, 28.7.1978, 4
- Walker, David. 'Thatcher floats her fears of benefits "time bomb"' *Times*, 25.1.1984, 5
- Whitehead, Tony (Anthony). In: Anon. 'Aged "could be spared misery"' *Guardian*, 7.10.1974, 6

Journals and periodicals²

- Ackner, Brian. Harris, Arthur. Oldham, A. 'Insulin treatment of schizophrenia; a controlled study' *Lancet* (1957) i: 607-611
- Affleck, James. 'Psychiatric disorders among the chronic sick in hospital' *Journal of Mental Science* (1948) 94: 33-45
- Amulree, Lord. 'Modern hospital treatment and the pensioner' *Lancet* (1955) ii: 571-575

² Includes newsletters of professional bodies circulated to members only.

- Amulree, Lord. Sturdee, Edwin. 'Care of the chronic sick and of the aged' *BMJ* (1946) i: 617-618
- Anderson, David. Connelly, Peter. Meier, Richard. McCracken, Cherie. 'Mental health service discrimination against older people' *The Psychiatrist* (2013) 37: 98-103
- Anderson, Edward. 'Prognosis of the depressions of later life' *Journal of Mental Science* (1936) 82: 559-588
- Anderson, John. 'The care of the elderly in general practice' *Research Newsletter* (RCGP) (1957) 4: 193-211
- Anderson, Robert. 'The unremitting burden on carers' *BMJ* (1987) 294: 73-74
- Anderson, William Ferguson. 'Difficulties in the management of sick old people' *Medical Press* (1956) 236: 341-345
- Anderson, William Ferguson. 'Geriatrics - a specialty?' *Interdisciplinary Topics in Gerontology* (1970) 5: 44-49
- Andrews, Charles. 'Early days in rural England' *Modern Geriatrics* (1971) 1: 117-122
- Andrews, Charles. Wilson, Thomas. 'The organisation of a geriatric service in a rural area' *Lancet* (1953) i: 785-789
- Andrews, James. 'Psychogeriatric assessment units' *Lancet* (1970) i: 1004
- Andrews, J. Bardon, D. Gander, DR. Gibson, KB. Mallett, BL. Robinson, KV. 'Planning of psychogeriatric care: report of a joint working party of geriatric physicians and psychiatrists' *Gerontologia Clinica* (1972) 14: 100-109
- Anon. 'Some common mental disorders' *Lancet* (1935) i: 327
- Anon. 'Book review' [Alfred Worcester, *Care of the Aged, the Dying and the Dead* (Springfield, Illinois: Thomas Books, 1935)] *Lancet* (1935) ii: 430
- Anon. 'Surgery in old age' *Lancet* (1937) i: 1180-1181
- Anon. 'The population problem' *Medical Press* (1938) 197: 393-394
- Anon. 'Surgery in old age' *Lancet* (1939) i: 1210-1211
- Anon. 'Mens sana' *Medical Press* (1940) 203: 297
- Anon. 'BMA Annual Meeting: summary of proceedings' *BMJ* (1948) ii: 89-104
- Anon. 'No room at the hospital' *Lancet* (1948) ii: 977
- Anon. 'Visit of her Royal Highness the Duchess of Kent to Bethlem on 21st July 1955' *Bethlem Maudsley Hospital Gazette* (1955) 2: 2: 45-51
- Anon. 'Human warehouses' *BMJ* (1961) ii: 100
- Anon. 'Old people's welfare services' *Almoner* (1961) 14: 379
- Anon. 'The aged in hospital' *Medical Press* (1961) 244: 303-305
- Anon. 'Hospitals for the aged' *Lancet* (1961) ii: 88-89
- Anon. 'Prospectus, Department of Extra-Mural Studies, University of London' *Almoner* (1961) 14: 288

- Anon. 'Editorial' *British Journal of Psychiatry* (1963) 109: 1
- Anon. 'The elderly: "living and partly living"' *Mental Health* (1963) 21: 210-211
- Anon. 'The elderly in hospital' *Lancet* (1967) ii: 85-86
- Anon. 'Not good enough' *Lancet* (1968) ii: 202-203
- Anon. 'Editorial' *Nursing Mirror*, 19.7.1968, 9
- Anon. 'The *Sans Everything* enquiries' *Nursing Mirror*, 19.7.1968, 12-13
- Anon. 'Psychiatric assessment of the elderly' *Lancet* (1970) i: 791
- Anon. 'BASW geriatric special interest group' *Social Work Today*, 18.10.1973, BASW News 4.14, 436
- Anon. 'University Departments' *News and Notes* (RCPsych) (July 1974) 7-9
- Anon. 'Election for elected members of Council' *News and Notes* (RCPsych) (Dec. 1975) 2
- Anon. 'Management of the demented patient in the community' *News and Notes* (RCPsych) (Feb. 1976) 3
- Anon. 'How to rescue geriatrics' *Lancet* (1977) i: 1091
- Anon. 'Providing a district service for general psychiatry, its special interests and related specialties: medical manpower priorities' *Psychiatric Bulletin* (Dec. 1977) 1: 5-7
- Anon. 'Meeting' *British Journal of Psychiatry* (1978) 132: 514-515
- Anon. 'Mental health of elderly people' *Lancet* (1979) i: 395
- Anon. 'Guidelines for collaboration between geriatric physicians and psychiatrists in the care of the elderly' *Psychiatric Bulletin* (1979) 3: 168-169
- Anon. 'Mentally ill: more resources needed' *BMJ* (1980) ii: 1228
- Anon. 'Personal clothing for long-stay patients' *Lancet* (1980) ii: 377-378
- Anon. 'Inequalities in health' *Lancet* (1980) ii: 513
- Anon. 'Caring for the aged' *BMJ* (1981) 282: 1817-1818
- Anon. 'Care of the elderly: is it a specialty?' *Lancet* (1985) ii: 459
- Anon. 'The truth about the NHS' *BMJ* (1986) 292: 1623-1624
- Anon. 'Report of meeting with RCPsych' *PSIGE Newsletter* (1987) 24: 18
- Argyle, N. Jestice, S. Brook, CPB. 'Psychogeriatric patients: their supporters' problems' *Age and Ageing* (1985) 14: 355-360
- Arie, Tom. 'The first year of the Goodmayes psychiatric service for old people' *Lancet* (1970) ii: 1179-1182
- Arie, Tom. 'Morale and the planning of psychogeriatric services' *BMJ* (1971) iii: 166-170
- Arie, Tom. 'Psychogeriatrics' *Age and Ageing* (1973) 2: 195-197

- Arie, Tom. 'Dementia in the elderly: diagnosis and assessment' *BMJ* (1973) iv: 540-543
- Arie, Tom. 'Married women doctors as part-time trainees' *BMJ* (1975) iii: 641-643
- Arie, Tom. 'Day care in geriatric psychiatry' *Gerontologia Clinica* (1975) 17: 31-39
- Arie, Tom. 'Day care in geriatric psychiatry, 1978' *Age and Ageing* (1979) 8: Supplement: 87-91
- Arie, Tom. 'Old age psychiatry over 15 years' *SPOA Newsletter* (1985) 7: 2-5
- Arie, Tom. Dunn, Tom. 'A "do-it-yourself" psychiatric-geriatrics joint patient unit' *Lancet* (1973) ii: 1313-1316
- Arie, Tom. Jolley, David. "'The Rising Tide'" *BMJ* (1983) 286: 325-326
- Asher, R. 'The dangers of going to bed' *BMJ* (1947) ii: 967-968
- Baines, S. Saxby, P. Ehler, K. 'Reality orientation and reminiscence therapy. A controlled cross-over study of elderly confused people' *British Journal of Psychiatry* (1987) 151: 222-231
- Baker, Alex. 'Hospital Advisory Service' *BMJ* (1972) i: 176-177
- Baker, Alex. 'The Hospital Advisory Service' *News and Notes* (RCPsych) (June 1973) 16-17
- Baker, Alex. 'Slow euthanasia – or "she will be better off in hospital"' *BMJ* (1976) ii: 571-572
- Baldwin, JA. Hall, DJ. 'Estimation of the outcome of a standing mental hospital population' *British Journal of Preventive and Social Medicine* (1967) 21: 56-65
- Baldwin, Robert. Jolley, David. 'The prognosis of depression in old age' *British Journal of Psychiatry* (1986) 149: 574-583
- Banks, A Leslie. 'Care of the infirm and the long-stay patient' *Monthly Bulletin of the Ministry of Health* (1944) 4: 112-118
- Batt, JC. 'Confusional mental states' *Medical Press* (1949) 222: 15-18
- Bebbington, Andrew. Charnley, Helen. 'Community care for the elderly - rhetoric and reality' *BJSW* (1990) 20: 409-432
- Bedford, Philip. 'General medical aspects of confusional states in elderly people' *BMJ* (1959) ii: 185-188
- Beresford, C. 'Senile dementia' *Nursing Times*, 6.7.1962, 861-864
- Bergmann, Klaus. 'Mental aspects of cerebrovascular disease' *Journal of the College of General Practitioners* (1969) 18: 84 Supplement 1: 7-14
- Bergmann, Klaus. 'Psychogeriatric services' *News and Notes* (RCPsych) (Aug. 1973) 6-8
- Bergmann, Klaus. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 672

- Bergmann, Klaus. Foster, E. Justice, A. Matthews, V. 'Management of the demented elderly patient in the community' *British Journal of Psychiatry* (1978) 132: 441-449
- Bickford, J. 'The forgotten patient. i. The problem reviewed' *Lancet* (1955) ii: 917-919
- Bickford, J. 'The forgotten patient. ii. One solution' *Lancet* (1955) ii: 969-971
- Birley, Jim. 'Psychiatrists and psychologists: co-operation or confrontation?' *Psychiatric Bulletin* (1985) 9: 123-125
- Birley, Jim. 'Psychogeriatrics: the smell of success or the odour of chronicity?' *International Journal of Geriatric Psychiatry* (1987) 2: 131-134
- Black, DAK. Pole, JD. 'Priorities in biomedical research: indices of burden' *British Journal of Preventive and Social Medicine* (1975) 29: 222-227
- Blessed, Garry. 'Psychogeriatrics in the nearly frozen north' *SPOA Newsletter* (Dec. 1980) 3-4
- Boucherat, Anne. 'Normalisation in mental handicap - acceptance without questions?' *Psychiatric Bulletin* (1987) 11: 423-425
- Bradley, J. 'Hospital Services for the Mentally Ill' *BMJ* (1971) 4: 811
- Brand, Daniel. Nicaise, Jean. 'Psychogeriatrics in Belgium: a brief overview' *Human Psychopharmacology: Clinical and Experimental* (1995) 10: Supplement 4: S219-S222
- Brearley, Paul. 'Social gerontology and social work' *British Journal of Social Work* (1976) 6: 433-447
- Brody, Morris. 'A psychometric study of dementia' *Journal of Mental Science* (1942) 88: 504-525
- Bromham, Beryl. 'A psychogeriatric unit in North Yorkshire' *SPOA Newsletter* (1985) 7: 14-17
- Brook, Peter. 'Assessors' reports on advisory appointments committees' *Psychiatric Bulletin* (1979) 3: 7-10
- Brook, Peter. 'Assessors reports on advisory appointments committees: changes since 1974' *Psychiatric Bulletin* (1989) 13: 16-19
- Brooke, Eileen. 'Recent progress in mental health statistics' *Monthly Bulletin of the Ministry of Health* (1958) 14: 208-215
- Brooke, Eileen. 'Factors affecting the demand for psychiatric beds' *Lancet* (1962) ii: 1211-1213
- Brooke, Eric. 'Care of the old in their homes' *Lancet* (1949) i: 462
- Brymer, C. Winograd, C. 'Fluoxetine in elderly patients: is there cause for concern?' *Journal of the American Geriatrics Society* (1992) 40: 902-905
- Burns, C. 'Geriatric care in general practice A medicosocial survey of 391 patients undertaken by health visitors' *Journal of the College of General Practitioners* (1969) 18: 287-296
- Burrowes, HP. 'Psychogeriatric assessment units' *Lancet* (1970) i: 1121

- Burton, R. Freeling, P. 'Unrecognized depression in general practice' *Journal of the Royal College of General Practitioners* (Occasional Paper) (1987) 36: 12-16
- Butler, Robert. 'Age-Isms: another form of bigotry' *Gerontologist* (1969) 9: 243-146
- Butrym, Zofia. 'Introduction to a discussion on casework with geriatric patients' *Almoner* (1963) 15: 325-332
- Caldicott, Fiona. 'The Short Report and its implications' *Psychiatric Bulletin* (1982) 6: 155-157
- Campbell, A. 'Admission of old people to hospital' *BMJ* (1976) ii: 812-813
- Carey, G. 'Undisclosed morbidity in persons aged over 70 in a Belfast general practice' *Journal of the College of General Practitioners* (1967) 14: Supplement 2: 43-52
- Carse, Joshua. Panton, Nydia. Watt, Alexander. 'A district mental health service: the Worthing experiment' *Lancet* (1958) i: 39-41
- Cawley, Robert. 'Planning for the future: report on a joint conference by the DHSS and the Royal College of Psychiatrists' *News and Notes* (RCPsych) (May 1973) 1-5
- Chandna, Shahid. Schulz, Joerg. Lawrence, Christopher. Greenwood, Roger. Farrington, Ken. 'Is there a rationale for rationing chronic dialysis? A hospital based cohort study of factors affecting survival and morbidity' *BMJ* (1999) 318: 217-223
- Chapman, Susan. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 495
- Charnley, John. 'Arthroplasty of the hip' *Lancet* (1961) i: 1129-1136
- Chiu, Edmond. Ames, David. 'Old age psychiatry Down Under' *Old Age Psychiatrist* (2011) 53: 37
- Chiu, Helen. 'A view from Hong Kong' *Old Age Psychiatrist* (2011) 53: 38
- Christie, Alex. Wood, Eric. 'Psychogeriatrics 1974-1984: expanding problems and fixed resources' *British Journal of Psychiatry* (1987) 151: 813-817
- Clarke, M. Hughes, AO. Dodd, KJ. Palmer, RL. Brandon, S. Holden, AM. 'The elderly in residential care: patterns of disability' *Health Trends* (1979) 11: 17-20
- Colwell, Catherine. 'Out for the day' *Bethlem Maudsley Hospital Gazette* (1954) 1: 182-183
- Comfort, Alex. 'On gerontophobia' *Medical Opinion and Review* (1967) 3: 9: 30-37
- Connelly, Peter. '21 years of old age psychiatry; then, now and the future' *Old Age Psychiatrist* (2011) 53: 16-17
- Connolly, John. 'The social and medical circumstances of old people admitted to a psychiatric hospital' *Medical Officer* (1962) 108: 95-100

- Connolly, John. Lumsden, M. Ross, D. 'The care of old people six months after admission to a psychiatric hospital' *Medical Officer* (1964) 111: 195-198
- Cook, Leslie. Dax, Eric. Maclay, Walter. 'The geriatric problem in mental Hospitals' *Lancet* (1952) i: 377-382
- Cooper, B. Brown, A. Kalton, G. 'A pilot study of psychiatric morbidity in general practice' *Journal of the College of General Practitioners* (1962) 5: 590-602
- Copeland, John. 'Prevalence of depressive illness in the elderly community' *Journal of the Royal College of General Practitioners* (Occasional Paper) (1987) 36: 5-8
- Copeland, John. Kelleher, MJ. Kellett, JM. Gourlay, AJ. Cowan, DW. Barron, G. De Gruchy, J. Gurland, BJ. Sharpe, L. Simon, R. Kuriansky, J. Stiller, P. 'Cross-National study of diagnosis of the mental disorders: a comparison of the diagnoses of elderly psychiatric patients admitted to mental hospitals serving Queens County, New York, and the former Borough of Camberwell, London' *British Journal of Psychiatry* (1975) 126: 11-20
- Copeland, John. Kelleher, MJ. Kellett, JM. Barron, G. Cowan, DW. Gourlay, AJ. 'Evaluation of a psychogeriatric service: the distinction between psychogeriatric and geriatric patients' *British Journal of Psychiatry* (1975) 126: 21-29
- Copeland, John. Kelleher, MJ. Kellett, JM. Gourlay, AJ. Gurland, BJ. Fleiss, JL. Sharpe, L. 'A semi-structured clinical interview for the assessment of diagnosis and mental state in the elderly: the Geriatric Mental State Schedule 1. Development and reliability' *Psychological Medicine* (1976) 6: 439-449
- Cosin, Lionel. Mort, Margaret. Post, Felix. Westropp, Celia. Williams, Moyra. 'Experimental treatment of persistent senile confusion' *International Journal of Social Psychiatry* (1958) 4: 24-42
- Currie, Colin. 'Doctors and ageism' *BMJ* (1987) 295: 1586
- Dax, Eric. Reitman, Francis. 'Hospitals for the aged and infirm' *BMJ* (1946) i: 736
- DeLargy, John. 'Six weeks in; 6 weeks out' *Lancet* (1957) i: 418-419
- Draper, Brian. 'The effectiveness of old age psychiatry services' *International Journal of Geriatric Psychiatry* (2000) 15: 687-703
- Draper, Brian. Low, Lee-Fay. 'What is the effectiveness of acute hospital treatment of older people with mental disorders?' *International Psychogeriatrics* (2005) 17: 539-555
- Eason, RJ. Grimes, JA. 'In-patient care of the mentally ill: a statistical study of future provision' *Health Trends* (1976) 8: 13-18
- Eisenberg, Leon. 'The relationship between psychiatric research and public policy' *British Journal of Psychiatry* (1988) 153: 21-29
- Enoch, M David. 'Care of the elderly disturbed patient' *Lancet* (1963) i: 1160-1161

- Evans, J Grimley. 'Integration of geriatric with general medical services in Newcastle' *Lancet* (1983) i: 1430-1433
- Evans, J Grimley. 'Service and research for an ageing population' *Age and Ageing* (2000) 29: Supplement 1: 5-8
- Exton-Smith, A Norman. 'Investigation of the aged sick in their homes' *BMJ* (1952) ii: 182-186
- Exton-Smith, Norman. Robinson, KV. 'Psychogeriatric assessment units' *Lancet* (1970) i: 1292
- Fairfield, Letitia. 'Care of the chronic sick' *Lancet* (1943) ii: 455-457
- Fine, Wilfred. 'Care of the elderly disturbed patient' *Lancet* (1963) i: 557
- Fish, Frank. Williamson, James (Jimmy). 'A delirium unit in an acute geriatric hospital' *Gerontologia Clinica* (1964) 6: 71-80
- Folsom, JC. 'Reality orientation for the elderly mental patient' *Journal of Geriatric Psychiatry* (1968) 1: 291-307
- Ford, Graeme. Taylor, Rex. 'The elderly as underconsulters: a critical reappraisal' *Journal of the Royal College of General Practitioners* (1985) 35: 244-247
- Foy, Jane. 'A survey of memory clinic practice in Scotland' *Psychiatric Bulletin* (2008) 32: 467-469
- Fries, James. 'Aging, natural death and the compression of morbidity' *New England Journal of Medicine* (1980) 303: 130-135
- Fry, John. 'A year of general practice: a study in morbidity' *BMJ* (1952) ii: 249-252
- Fry, John. 'The Keppel Club 1952-74: lessons from the past for the future' *BMJ* (1991) 303: 1596-1597
- Garland, Jeff. 'Knowing where to start: establishing a service for the elderly' *PSIGE Newsletter* (1982) 6:
- Garland, Jeff. 'Some distinguishing features of psychological practice with older people' *PSIGE Newsletter* (1988) 27: 3-7
- Gaspar, D. 'Hollymoor Hospital dementia services: analysis of outcome of 230 consecutive referrals to a psychiatric-hospital dementia service' *Lancet* (1980) i: 1402-1405
- Gibson, Ronald. 'The care of the elderly in general practice' *Research Newsletter (RCGP)* (1957) 4: 99-114
- Gilleard, Chris. Belford, H. Gilleard, E. Whittick, JE. Gledhill, K. 'Emotional distress amongst the supporters of the elderly mentally infirm' *British Journal of Psychiatry* (1984) 145: 172-177
- Ginzberg, Raphael. 'Attitude therapy in geriatric ward psychiatry' *Journal of the American Geriatrics Society* (1955) 3: 445-462
- Glover, Gyles. Farmer, Richard. Preston, David. 'Indicators of mental hospital bed use' *Health Trends* (1990) 22: 111-115

- Godber, Colin. 'Mental health of elderly people - MIND's response to the DHSS discussion paper *A Happier Old Age* (MIND, 1979)' *Psychiatric Bulletin* (1979) 3: 139
- Godber, Colin. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 495
- Graham, Helen. 'MRCGP candidates and the elderly' *Journal of the Royal College of General Practitioners* (1987) 37: 85
- Gray, JA Muir. 'Geriatrics, politics and the BGS' *Age and Ageing* (1976) 5: 125-126
- Gray, Muir. 'Admission of old people to hospital' *BMJ* (1976) ii: 1007
- Greatorex, Barry. 'Ageism and the professional psychologist' *PSIGE Newsletter* (1982) 5:
- Green, Mary. 'Aspects of old age' *British Journal of Social Work* (1977) 7: 301-320
- Grundy, Emily. Glaser, Karen. 'Trends in, and transitions to, institutional residence among older people in England and Wales, 1971-91' *Journal of Epidemiology and Community Health* (1997) 51: 531-540
- Hadden, Sue. 'The essence of our care: a nursing perspective' *Old Age Psychiatrist* (2011) 53: 24-25
- Harris, Arthur. 'What can the general practitioner expect of the psychiatrist?' *Medical Press* (1953) 229: 297-300
- Harris, Noel. 'Parnham' *Mental Health* (1963) 21: 218-221
- Harrison, Paul. 'The careless community' *New Society*, 28.6.1973, 743-745
- Harrison, Paul. 'The old under control: a case study' *New Society*, 31.1.1974, 249-252
- Hart, Julian Tudor. 'The inverse care law' *Lancet* (1971) 297: 405-412
- Hilton, Claire. Jolley, David. (ed.) *Old Age Psychiatrist* (2011) 53:
- Hobson, W. Pemberton, J. 'The health of the elderly at home' *BMJ* (1956) i: 587-593
- Hodkinson, Malcolm. Evans, G. Mezey, A. 'Factors associated with misplacement of elderly patients in geriatric and psychiatric hospitals' *Gerontologia Clinica* (1972) 14: 267-273
- Holden, Una. Chairman's letter, *PSIGE Newsletter* (1982) 5:
- Holman, Robert. 'Poverty: consensus and alternatives' *BJSW* (1973) 3: 431-446
- Hopkins, Philip. Cooper, Brian. 'Psychiatric referral from a general practice' *British Journal of Psychiatry* (1969) 115: 1163-1174
- Horrocks, Peter. 'The components of a comprehensive district health service for elderly people – a personal view' *Age and Ageing* (1986) 15: 321-342
- Howell, Trevor. 'Old age in general practice' *Proceedings of the Royal Society of Medicine* (1948) 41: 337

- Howell, Trevor. 'The problem of the chronic sick' *Medical Press* (1951) 225: 505-507
- Humphreys, H. 'Care in the community' *Journal of the Royal College of General Practitioners* (1984) 34: 361-363
- Hurst, Lindsay. Morton, Eric. 'Psychogeriatric assessment units' *Lancet* (1970) ii: 47-48
- Inglis, J. 'A paired-associate learning test for use with elderly psychiatric patients' *Journal of Mental Science* (1959) 105: 440-443
- Inglis, J. Colwell, Catherine. Post, Felix. 'An evaluation of the predictive power of a test known to differentiate between elderly "functional" and "organic" psychiatric patients' *Journal of Mental Science* (1960) 106: 1486-1492
- International Journal of Geriatric Psychiatry*, Editorial Board (1986) 1: 1
- Isaacs, Anthony. 'Geriatric psychiatry' *Psychiatric Quarterly* (1974) 48: 513-519
- Isaacs, Bernard. 'Let's abolish "the elderly"' *BMJ* (1982) 284: 112
- Jachuck, S. Stobo, S. Sahgal, A. 'Evaluation of the mental function of the elderly in a general practice' *Journal of the Royal College of General Practitioners* (1986) 36: 123-124
- Johnstone, Eve. Deakin, J. Lawler, P. Frith, C. Stevens, M. McPherson, K. Crow, T. 'The Northwick Park electroconvulsive therapy trial' *Lancet* (1980) ii: 1317-1320
- Jolley, David. 'Admission of old people to hospital' *BMJ* (1976) ii: 696
- Jolley, David. 'Hospital inpatient provision for patients with dementia' *BMJ* (1977) i: 1335-1336
- Jolley, David. 'Editorial' *SPOA Newsletter* (1982) 4: 1
- Jolley, David. 'Editorial' *SPOA Newsletter* (1985) 7: 14
- Jolley, David. 'Editorial' *SPOA Newsletter* (1985/6) 8: 7
- Jolley, David. 'England expects: more than we can provide' *Psychiatric Bulletin* (1989) 13: 248-249
- Jolley, David. Arie, Tom. 'Psychiatric service for the elderly: how many beds?' *British Journal of Psychiatry* (1976) 129: 418-423
- Jolley, David. Arie, Tom. 'Organisation of psychogeriatric services' *British Journal of Psychiatry* (1978) 132: 1-11
- Jones, DA. Vetter, NJ. 'Formal and informal support received by carers of elderly dependents' *BMJ* (1985) 291: 643-645
- Joy, Michael. Huggett, Isabel. 'Cardiology in a district hospital' *BMJ* (1982) 285: 790-792
- Kalashe, Alexandre. Aboderin, Isabella. Hoskins, Irene. 'Compression of morbidity and active ageing: key priorities for public health policy in the 21st century' *Bulletin of the World Health Organisation* (2002) 80: 243-244

- Kay, David. Beamish, Pamela. Roth, Martin. 'Some medical and social characteristics of elderly people under state care' *Sociological Review Monograph* (1962) 5: 173-193
- Kay, David. Beamish, Pamela. Roth, Martin. 'Old age mental disorders in Newcastle upon Tyne: i. a study of prevalence' *British Journal of Psychiatry* (1964) 110: 146-158
- Kay, David. Beamish, Pamela. Roth, Martin. 'Old age mental disorders in Newcastle upon Tyne: ii. a study of possible social and medical causes' *British Journal of Psychiatry* (1964) 110: 668-682
- Kay, David. Roth, Martin. Hall, Michael. 'Special problems of the aged and the organisation of hospital services' *BMJ* (1966) ii: 967-972
- Kay, David. Bergmann, Klaus. Forster, Eleanor. McKechnie, Alasdair. Roth, Martin. 'Mental illness and hospital usage in the elderly: a random sample followed up' *Comprehensive Psychiatry* (1970) 11: 26-35
- Kendell, Robert. 'The future of psychiatric research in Britain' *Bethlem Maudsley Gazette* (1987) 34: 3: 24-25
- Kennedy, R. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 671
- Khoosal, DI. Jones, PH. 'Community care again: a need for definition' *Journal of the Royal Society of Medicine* (1989) 82: 451-452
- Kidd, Cecil. 'Rejection of the seventh age: society and the aged sick' *Almoner* (1962) 14: 452-457
- Kidd, Cecil. 'Misplacement of the elderly in hospital: a study of patients admitted to geriatric and mental hospitals' *BMJ* (1962) ii: 1491-1495
- Kino, F. Thorpe, F. 'Electrical convulsion therapy in 500 selected psychotics' *Journal of Mental Science* (1946) 92: 138-145
- Kinsler, Hilary. 'Memories from Goodmayes' *OAP* (2011) 53: 9-10
- Kirby, Liz. Lehmann, Petra. Majeed, Azeem. 'Dementia in people aged 65 years and older: a growing problem?' *Population Trends* (1998) 92: 23-28
- Kolb, Lawrence. 'The mental hospitalisation of the aged: is it being overdone?' *American Journal of Psychiatry* (1956) 112: 627-635
- Langley, Gordon. Simpson, J. 'Misplacement of the elderly in geriatric and psychiatric hospitals' *Gerontologia Clinica* (1970) 12: 149-163
- Langley, Gordon. Wright, W. Sowden, R. Cobby, J. 'The Exe Vale joint psycho-geriatric assessment unit (Hallett Clinic)' *Age and Ageing* (1975) 4: 125-128
- Last, Samuel. 'Mental disorders in old age' *Medical Press* (1939) 202: 329-332
- Last, Samuel. 'Conditions in psychiatric hospitals' *Lancet* (1969) i: 884
- Lawton, G. 'Old age and ageing: the present state of scientific knowledge' *American Journal of Orthopsychiatry* (1940) 10: 27-87
- Lee, Maggie. 'And what about occupational therapy?!' *Old Age Psychiatrist* (2011) 53: 26-27

- Levy, Raymond. 'Obstacles to research in geriatric psychiatry' *International Journal of Geriatric Psychiatry* (1986) 1: 83-84
- Levy, Raymond. 'An old age psychiatrist at work and play: a research perspective' *Old Age Psychiatrist* (2011) 53: 33-35
- Lewis, Aubrey. 'The education of psychiatrists' *Lancet* (1947) ii: 79-83
- Lewis, Aubrey. Goldschmidt, Helen. 'Social causes for admission to a mental hospital for the aged' *Sociological Review* (1943) 35: 86-98
- Lindesay, James. Murphy, Elaine. 'Suicide in old age' *International Journal of Geriatric Psychiatry* (1987) 2: 71-72
- Lindsay, JSB. 'Trend in mental-hospital planning and their effect on planning' *Lancet* (1962) i: 1354-1355
- Livesley, Brian. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 496
- Lowther, CP. Williamson, James (Jimmy). 'Old people and their relatives' *Lancet* (1966) ii: 1459-1460
- MacDonald, Alastair. 'Do general practitioners "miss" depression in elderly patients?' *BMJ* (1986) 292: 1365-1367
- McKie, David. 'Those two reorganisations' *Lancet* (1973) ii: 1434
- Macmillan, Duncan. 'Preventive geriatrics' *Lancet* (1960) ii: 1439-1441
- Macmillan, Duncan. 'Community mental health services and the mental hospital' *World Mental Health* (1961) 13: 46-58
- Macmillan, Duncan. 'Problems of a geriatric mental health service' *British Journal of Psychiatry* (1967) 113: 175-181
- Malzberg, Benjamin. 'The frequency of mental disease: a study of trends in New York state' *Acta Psychiatrica Scandinavica* (1963) 39: 19-30
- Marshall, Mary. 'A social worker's perspective' *Old Age Psychiatrist* (2011) 53: 28
- Mayer-Gross, Willy. 'Arteriosclerotic, senile and presenile psychoses' *Journal of Mental Science* (1944) 90: 316-327
- Mayer-Gross, Willy. 'Electric convulsion treatment in patients over 60' *Journal of Mental Science* (1945) 91: 101-103
- Melville, Donald. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 672
- Millar, HR. 'Psychiatric morbidity in elderly surgical patients' *British Journal of Psychiatry* (1981) 138: 17-20
- Millard, Peter. 'Last scene of all' *BMJ* (1981) 283: 1559-1560
- Millard, Peter. Higgs, P. Rochon, P. 'Aging: should it be left to chance?' *BMJ* (1989) 298: 1020-1021
- Moore, Matthew. 'Electrocerebral shock therapy: a reconsideration of former contraindications' *Archives of Neurology and Psychiatry* (1947) 57: 693-711

- Morris, Jacqueline. 'Old age physicians and psychiatrists: past, present and future collaboration' *Old Age Psychiatrist* (2011) 53: 21-22
- Morton, Eric. Barker, ME. Macmillan, Duncan. 'The joint assessment and early treatment unit in psycho-geriatric care' *Gerontologia Clinica* (1968) 10: 65-73
- Murphy, Elaine. 'Hazards for elderly people admitted for respite and social care' *BMJ* (1986) 292: 481-482
- Murphy, Elaine. 'The new journal, its present state and prognosis' *International Journal of Geriatric Psychiatry* (1988) 3: 77
- Murphy, Elaine. 'Griffiths on community care: potentially disastrous' *BMJ* (1988) 296: 876-877
- Murphy, Elaine. 'Government must act on community care' *BMJ* (1988) 297: 1558-1559
- Nascher, Ignatz. 'Geriatrics' *New York Medical Journal* (1909) 90: 358-359
- Neville, Richard. 'Psychogeriatric day hospitals' *Nursing Mirror*, 11.8.1967, ix-x
- Norton, Alan. 'Mental hospital ins and outs: a survey of patients admitted to a mental hospital in the past 30 years' *BMJ* (1961) i: 528-535
- Norton, Doreen. 'The place of geriatric nursing in training' *Nursing Times*, 6.7.1956, 621-624
- Oddie, JA. Hassler, JC. Vine, SM. Bennett, AE. 'The community hospital: a pilot trial' *Lancet* (1971) ii: 308-310
- Oliver, Judith. 'Hazards for elderly people admitted for respite and social care' *BMJ* (1986) 292: 481
- Olshansky, Simon. 'Stigma: its meaning and some of its problems for vocational rehabilitation agencies' *Rehabilitation Literature* (1965) 26: 71-74
- Park, Mungo. 'Hospitals for the aged and infirm' *BMJ* (1946) i: 549
- Parsons, P. 'Mental health of Swansea's old folk' *British Journal of Preventive and Social Medicine* (1965) 19: 43-47
- Petrie, Alfred. 'Mental health services - present and future' *Journal of Mental Science* (1944) 90: 3-19
- Pickering, Thomas. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 377, 791
- Pitt, Brice. 'Group for the psychiatry of old age' *News and Notes (RCPsych)* (May 1975) 21
- Pitt, Brice. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 494-495
- Pitt, Brice. Silver, Chris. 'The combined approach to geriatrics and psychiatry: evaluation of a joint unit in a teaching hospital district' *Age and Ageing* (1980) 9: 33-37

- Pope, Catherine. Mays, Nick. 'Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research' *BMJ* (1995) 311: 42-45
- Post, Felix. 'Some problems arising from a study of mental patients over the age of 60 years' *Journal of Mental Science* (1944) 90: 554-565
- Post, Felix. 'Mental aspects of senescence' *British Medical Bulletin* (1949) 6: 54-57
- Post, Felix. 'Geriatric Unit' *Bethlem Maudsley Hospital Gazette* (1955) 1: 270-271
- Post, Felix. 'Emergencies in general practice: senile confusion' *BMJ* (1955) ii: 315-317
- Post, Felix. 'Management of senile psychiatric disorders' *BMJ* (1968) 4: 627-630
- Post, Felix. 'Admission of old people to hospital' *BMJ* (1976) ii: 696
- Post, Felix. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 496
- Prinsley, D. 'Psychogeriatric ward for mentally disturbed elderly patients' *BMJ* (1973) iii: 574-577
- Rai G. Bielawska, C. Murphy, P. Wright, G. 'Hazards for elderly people admitted for respite ("holiday admissions") and social care ("social admissions")' *BMJ* (1986) 292: 240
- Rajapakse, Anoja. Bussin, Jacqui. 'Prevalence of challenging behaviour among older in-patients: a pilot study' *Psychiatric Bulletin* (2009) 33: 277-278
- Ratoff, Len. 'Seebohm and the mental health services: reflections from general practice' *Social Work Today*, 2.11.1972, 3: 15: 3-6
- Reifler, Burton. Cohen, Wayne. 'Practice of geriatric psychiatry and mental health services for the elderly: results of an international survey' *International Psychogeriatrics* (1998) 10: 351-357
- Richards, Tessa. 'Research into aging: exploding myths' *BMJ* (1988) 296: 659
- Robinson, Kenneth. 'Public attitudes to mental disorder' *British Journal of Psychiatric Social Work* (1957) 4: 28-29
- Robson, J. Iliffe, S. LeFanu, J. 'Reorganisation of the NHS' *Lancet* (1972) ii: 648-649
- Rogers, J Kenyon. 'Service for the elderly: a special interest group' *SWT* 1.11.73, BASW News, 4.15 470
- Rogers, JS. 'Growing older but not happier' *Lancet* (1981) ii: 84-85
- Ross, DN. 'Geriatric day hospitals: counting the cost compared with other methods of support' *Age and Ageing* (1976) 5: 171-175
- Rosser, RM. Watts, VC. 'The measurement of hospital output' *International Journal of Epidemiology* (1972) 1: 361-368

- Roth, Martin. 'The natural history of mental disorders in old age' *Journal of Mental Science* (1955) 101: 281-301
- Roth, Martin. Morrissey, John. 'Problems in the diagnosis and classification of mental disorder in old age: with a study of case material' *Journal of Mental Science* (1952) 98: 66-80
- Roth, Martin. Hopkins, Barbara. 'Psychological test performance in patients over 60: i. Senile psychosis and the affective disorders of old age' *Journal of Mental Science* (1953) 99: 439-450
- Russell, Ivison. 'The role of the mental hospital in the National Health Service' *Journal of Mental Science* (1949) 95: 785-794
- Sampey, Alex. 'Trends in the mental health services' *Journal of the College of General Practitioners* (1962) 5: 302-304
- Searle, DJ. 'The psychogeriatric services: report of a conference held at the Hospital Centre, London on Sept 9th' *Nursing Mirror*, 25.9.1970, 10-11
- Sedgwick, Peter. 'The fate of psychiatry in the new populism' *Psychiatric Bulletin* (1983) 7: 22-25
- Shepherd, Michael. 'Psychiatric research in perspective' *BMJ* (1981) 282: 961-963
- Sleight, Peter. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 791
- Smart, George. 'The state of British medicine - 3: the British Postgraduate Medical Federation' *Journal of the Royal Society of Medicine* (1978) 71: 167-169
- Smith, Christopher. Ebrahim, Shah. Arie, Tom. 'Drug trials, the 'elderly' and the very aged' *Lancet* (1983) ii: 1139
- Smith, R. Williams, B. 'A survey of undergraduate teaching of geriatric medicine in the British medical schools' *Age and Ageing* (1983) 12: Supplement: 2-6
- Smith, S. Gibb, G. Martin A. 'Metamorphosis of a mental hospital' *Lancet* (1960) ii: 592-593
- Smith, SLH. 'Admission of old people to hospital' *BMJ* (1976) ii: 696
- Sneddon, Ronald. 'Psychiatric geriatric assessment unit at Crichton Royal Hospital' *Nursing Mirror*, 7.4.1967, x-xv
- Steel, Robin. 'Psychiatric disorders in general practice' *Journal of the Royal College of General Practitioners* (1981) 31: 765-766
- Stengel, Erwin. 'A study on the symptomatology and differential diagnosis of Alzheimer's disease and Pick's disease' *Journal of Mental Science* (1943) 89: 1-20
- Taylor, Rex. Buckley, Graham. (ed.) 'Preventive Care of the Elderly: a review of current developments' *Journal of the Royal College of General Practitioners* (Occasional Paper) (1987) 35: 1-53
- Tepper, R. 'Admission of old people to hospital' *BMJ* (1976) ii: 812

- Tewfik, GI. 'A review of the psychotic elderly resident in a mental hospital' *Journal of Mental Science* (1956) 102: 247-263
- Thompson, M Keith. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 495-496
- Thompson, M Keith. 'Care of the elderly' *Journal of the Royal College of General Practitioners* (1987) 37: 133
- Thomson, A. 'Discussion on the problems of old age' *Proceedings of the Royal Society of Medicine* (1950) 43: 929-933
- Thomson, W. 'The elderly who live alone' *Medical Press* (1959) 242: 477-480
- Timbury, Gerald. 'Training in the psychiatry of old age' *Psychiatric Bulletin* (1981) 5: 173
- Tooth, Geoffrey. Brooke, Eileen. 'Trends in the mental hospital population and their effect on future planning' *Lancet* (1961) i: 710-713
- Townsend, Peter. 'The structured dependency of the elderly: a creation of social policy in the twentieth century' *Ageing and Society* (1981) 1: 5-28
- Tucker, Diana. 'Number of mental health beds' *Lancet* (1972) ii: 971
- Tucker, Diana. 'Depression on holiday' *BMJ* (1976) ii: 1074
- Turnbull, Christopher. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 992
- Turner, R. Roberts, G. 'The Worcester Development Project' *British Journal of Psychiatry* (1992) 160: 103-107
- Van der Cammen, Tischa. Simpson, J. Fraser, R. Preker, A. Exton-Smith, AN. 'The memory clinic' *British Journal of Psychiatry* (1987) 150: 359-364
- Vojtechovský, Miloš. 'The development of old age psychiatry in the Czech Republic' *Human Psychopharmacology: Clinical and Experimental* (1995) 10: Supplement 4: S213-S218
- Warren, Marjory. 'Care of chronic sick' *BMJ* (1943) ii: 822-823
- Warren, Marjory. 'Care of the chronic aged sick' *Lancet* (1946) ii: 841-843
- Warren, Marjory. 'The evolution of a geriatric unit from a public assistance institution, 1935-47' *Proceedings of the Royal Society of Medicine* (1948) 41: 337-338
- Wattis, John. 'Measuring performance or balancing the budget' *BMJ* (1987) 295: 1000
- Wattis, John. 'Geographical variations in the provision of psychiatric services for old people' *Age and Ageing* (1988) 17: 171-180
- Wattis, John. 'Old age psychiatrists in the United Kingdom – their educational role' *International Journal of Geriatric Psychiatry* (1989) 4: 361-363
- Wattis, John. 'A comparison of 'specialized' and 'non-specialized' psychiatric services for old people in the United Kingdom' *International Journal of Geriatric Psychiatry* (1989) 4: 59-62

- Wattis, John. Wattis, Libby. Arie, Tom. 'Psychogeriatrics: a national survey of a new branch of psychiatry' *BMJ* (1981) i: 1529-1533
- Wattis, John. Arie, Tom. 'Further developments in psychogeriatrics in Britain' *BMJ* (1984) 289: 778
- Wattis, John. Smith, CW. Binns, V. 'Medical students' attitudes to old people and career preferences: a comparison of two universities' *Medical Education* (1986) 20: 498-501
- White, (Michael) DMD. 'Psychogeriatrics – what next?' *Lancet* (1972) ii: 223-224
- White, DMD. 'What's wrong with psychogeriatrics?' *Psychiatric Bulletin* (1979) 3: 89-90
- White, DMD. 'Moving on' *SPOA Newsletter* (1981) 3: 12-14
- White, DMD. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 495
- Whitehead, Anthony (Tony). 'A comprehensive psychogeriatric service' *Lancet* (1965) ii: 583-586
- Whitehead, Anthony. 'Conditions in psychiatric hospitals' *Lancet* (1969) i: 983
- Whitehead, J Anthony. 'Now tell us how to solve the psychogeriatric problem of the psychiatric hospitals' *News and Notes* (RCPsych) (Aug. 1972) 4-5
- Whitehead, Tony. 'Book review' [Brice Pitt, *Psychogeriatrics: an introduction to the psychiatry of old age* (Edinburgh: Churchill Livingstone, 1974)] *Age and Ageing* (1976) 5: 63
- Whitehead, Tony. 'Closing large mental hospitals' *Lancet* (1983) ii: 1139-1140
- Wigley, Guy. 'Community services for mentally infirm old people' *Lancet* (1968) ii: 963-966
- Wilkin, David. Williams, E Idris. 'Patterns of care for the elderly in general practice' *Journal of the Royal College of General Practitioners* (1986) 36: 567-570
- Williamson, James (Jimmy). 'Screening examinations in old age' *Journal of the College of General Practitioners* (1966) 11: Supplement 1: 89-93
- Williamson, James. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 671-672
- Williamson, James. Stokoe, IH. Gray, S. Fisher, M. 'Old people at home: their unreported needs' *Lancet* (1964) i: 1117-1120
- Wilson, EMA. 'The home helps scheme in Leicester' *Nursing Mirror*, 11.12.1948, ii-iv
- Wilson, Leslie. 'Psychogeriatric assessment units' *Lancet* (1970) ii: 468
- Winyard, G. 'The future of cardiology and psychogeriatrics' *BMJ* (1981) 283: 496
- Wright, Barbara. 'Society and the individual' *Almoner* (1963) 16: 1: 18

Websites:³ primary sources

Bolam v. Friern Hospital Management Committee (1957): Queens Bench Division
http://oxcheps.new.ox.ac.uk/casebook/Resources/BOLAMV_1%20DOC.pdf
accessed 1.6.2010

BBC

BBC News, 'Dementia: PM promises push to tackle 'national crisis'' 26.3.2012
<http://www.bbc.co.uk/news/health-17507678> accessed 19.5.2012

British Film Institute

BBC, *The Hurt Mind* (1957)
<http://ftvdb.bfi.org.uk/sift/title/10718?view=synopsis> accessed 25.9.2010

British Geriatrics Society

British Geriatrics Society / Royal College of Psychiatrists, 'Guidelines for collaboration between physicians of geriatric medicine and psychiatrists of old age' (2007)
http://www.bgs.org.uk/index.php?option=com_content&view=article&id=361:geriatricianpsychiatristcollaboration&catid=12:goodpractice&Itemid=106
accessed 30.4.2013

Centre for Health Economics, York

<http://www.york.ac.uk/che/publications/in-house/archive/1980s/> accessed 19.11.2012

Bosanquet, Nick. 'Public expenditure rules and the NHS' (York: Centre for Health Economics, 1985)

Carr-Hill, Roy. 'Revising the RAWP formula: indexing deprivation and modelling demand' (York: Centre for Health Economics, 1988)

Archive of Conservative Party Manifestos

General Election Manifesto (1979) <http://www.conservative-party.net/manifestos/1979/1979-conservative-manifesto.shtml> accessed 28.5.2011

Guardian

<http://www.guardian.co.uk/> and <http://www.guardian.co.uk/gnm-archive>
accessed 18.6.2013

³ Excluding websites of full-text journals and books which are readily available in hard copy

Hansard

<http://hansard.millbanksystems.com/> and <http://www.theyworkforyou.com>
accessed 30.4.2013

Health Service Ombudsman

Care and Compassion: report of the Health Service ombudsman on ten investigations into NHS care of older people (2011)
<http://www.ombudsman.org.uk/care-and-compassion> accessed 3.7.2011

Personal Social Services Research Unit

Jolley, David. Jolley, Susan. 'Guthrie Trust Witness Seminar' (PSSRU: Manchester, 2008)
<http://www.medicine.manchester.ac.uk/pssru/newsandevents/gtwseminarsummary.pdf> accessed 14.4.2013

Netten, Anne. Bebbington, Andrew. Darton, Robin. Forder, Julien. Miles, Kathryn. *1996 Survey of Care Homes for Elderly People* PSSRU discussion paper 1423/2 (1998) www.pssru.ac.uk/pdf/dp1423~2.pdf accessed 14.3.2011

Wittenberg, Raphael. Pickard, Linda. Comas-Herrera, Adelina. Davies, Bleddyn. Darton, Robin. *Demand for Long-term Care: projections of long-term care finance for elderly people* (Kent: PSSRU, 1998)
www.pssru.ac.uk/pdf/lcrep98.pdf accessed 31.1.2013

Nuffield Provisional Hospitals Trust

On-line archive of full text reports <http://www.nuffieldtrust.org.uk/> accessed 5.6.2013

Office of Health Economics

'UK resident population and projections by age group, 1948-2051'
<http://www.ohe.org/page/health-statistics/access-the-data/demographics/data.cfm> accessed 17.1.2013

Organisation for Economic Co-operation and Development

'Health expenditure as a share of GDP, 1960-2009, selected OECD countries'
<http://dx.doi.org/10.1787/888932523215> accessed 13.3.2013

Patients Association

Wasson, Peter. *We've been listening, have you been learning?* (2011)
<http://patients-association.com/default.aspx?tabid=80&Id=23> accessed 21.10.2012

Royal College of Physicians

Hospitals on the Edge? The time for action (2012)

<http://www.rcplondon.ac.uk/projects/hospitals-edge-time-action> accessed 11.12.2012

Royal College of Psychiatrists

Old Age Psychiatrist, Old Age Faculty newsletters

<http://www.rcpsych.ac.uk/workinpsychiatry/faculties/oldage/aboutthefaculty/newsletters.aspx> accessed 9.6.2013

Times Digital Archive

http://infotrac.galegroup.com/itw/infomark/0/1/1/purl=rc6_TTDA?sw_aep=bar_ttda accessed 12.5.2013

University of Glasgow

Guthrie Trust Witness Seminar 2008, *The Development of Old Age Psychiatry in Britain 1960-1989* ed. Claire Hilton (University of Glasgow, 2009)

www.gla.ac.uk/media/media_196526_en.pdf accessed 30.4.2013

World Health Organisation

On-line library of full text reports <http://apps.who.int/iris/> accessed 5.6.2013

Creative literature

Kesey, Ken. *One Flew over the Cuckoo's Nest* (London: Methuen, 1963)

McCartney, Paul. Lennon, John. 'When I'm 64' (The Beatles, 1967)

Shakespeare, William. *As You Like It* In: *The Complete Works of William Shakespeare* (Glasgow: Harper Collins, 1951, 1994 printing)

Smith, Ken. Sweeney, Matthew. (ed.) *Beyond Bedlam: poems written out of mental distress* (London: Anvil Press, 1997)

Townshend, Pete. 'My Generation' (The Who, 1965)

Reference books

Medical Directory (London: JA Churchill, 1970)

Medical Directory (London: JA Churchill, 1973)

Autobiographies, memoirs, biographies, diaries and obituaries

(see 'Witness seminar')

Altschul, Annie

Barker, Phil. 'Annie Altschul: Progressive champion of psychiatric nursing' *Guardian*, 8.1.2002
<http://www.guardian.co.uk/society/2002/jan/08/mentalhealth> accessed 16.3.2013

Amulree, Basil Mackenzie, Lord

Denham, Michael. 'Lord Amulree: an appreciation' *Age and Ageing* (2005) 34: 529-531

Anderson, (William) Ferguson

Brocklehurst, John. 'Anderson, Sir (William) Ferguson (1914-2001)', *Oxford Dictionary of National Biography*, OUP, Oct 2008
<http://www.oxforddnb.com/view/article/89563> accessed 22.6.2010

Barton, Russell

Jolley, David. 'Remembering Russell Barton' *Psychiatric Bulletin* (2003) 27: 233-234

Rollin, Henry. 'Russell William Andrew Charles Barton' *Psychiatric Bulletin* (2003) 27: 35

Blacker, Carlos

Soloway, Richard. 'Blacker, Carlos Paton (1895-1975)' *Oxford Dictionary of National Biography*, OUP, 2004 <http://www.oxforddnb.com/view/article/47726> accessed 4.6.2012

Carling, Ernest Rock

Cade, Stanford. 'Carling, Sir Ernest Rock (1877-1960)', *Oxford Dictionary of National Biography*, OUP, 2004 <http://www.oxforddnb.com/view/article/32290> accessed 21.3.2013

Cosin, Lionel

Irvine, RE. 'LZ Cosin' *BMJ* (1994) 309: 189

Crossman, Richard.

Crossman, Richard. *The Diaries of a Cabinet Minister, Vol. 3. Secretary of State for Social Services 1968-1970* (London: Hamilton and Cape, 1977)

Exton- Smith, Arthur Norman see: *Smith*

Freudenberg, Rudolf

DB, 'Rudolf Karl Freudenberg' *Psychiatric Bulletin* (1983) 7: 215

Becker, Thomas. Bennett, Douglas. 'Rudolf Karl Freudenberg - from pioneer of insulin treatment to pioneering social psychiatrist' *History of Psychiatry* (2000) 11: 189-211

Godber, George

Black, Douglas. 'Sir George Godber' *Guardian*, 11.2.2009

<http://www.guardian.co.uk/society/2009/feb/11/sir-george-godber-obituary>
accessed 17.5.2013

Henderson, David

Loughlin, K. 'Henderson, Sir David Kennedy (1884-1965)', *Oxford Dictionary of National Biography*, OUP, 2004

<http://www.oxforddnb.com/view/article/47296> accessed 30.12.2011

Howe, Geoffrey

Howe, Geoffrey. *Conflict of Loyalty* (London: Macmillan, 1994)

Isaacs, Bernard

Arie, Tom. 'Isaacs, Bernard (1924-1995)', *Oxford Dictionary of National Biography*, OUP, 2008 <http://www.oxforddnb.com/view/article/58197>
accessed 22.6.2010

Jolley, David

Jolley, David. 'Psychiatrist into psychogeriatrician' *News and Notes* (RCPsych) (Nov. 1976) 11-13

Kahlbaum, Karl Ludwig

Braünig, Peter. Krüger, Stephanie. 'Karl Ludwig Kahlbaum MD (1828-1899)' *American Journal of Psychiatry* (1999) 156: 989

Last, Samuel

Watt, David. 'Samuel Last' *BMJ* (1991) 303: 577

Lewis, Aubrey

Gelder, Michael. 'Sir Aubrey Lewis's contributions to psychiatry' *British Journal of Psychiatry* (1976) 128: 31-35

Jones, Edgar. 'Aubrey Lewis, Edward Mapother and the Maudsley' *Medical History* (2003) Supplement 22: 3-38

Series, Hugh. 'Lewis, Sir Aubrey Julian (1900-1975)', *Oxford Dictionary of National Biography*, OUP, 2004 <http://www.oxforddnb.com/view/article/31359> accessed 3.10.2011

Shepherd, Michael. 'A representative psychiatrist: the career, contributions and legacies of Sir Aubrey Lewis' *Psychological Medicine Monograph* (1986) Supplement 10: 5-31

Maclay, Walter

Anon. 'Walter Maclay' *Bethlem Maudsley Hospital Gazette* (1961) 4: 1: 30-34

Macmillan, Duncan

HF, 'D Macmillan' *BMJ* (1970) i: 119

Marshall, Mary

Murphy, Elaine. 'Mary Marshall OBE: an appreciation' 6-8. In: *Mary Marshall: an e-festschrift*. PSSRU, University of Manchester, 2005 <http://www.nursing.manchester.ac.uk/pssru/research/nwdc/news/marymarshall.pdf> accessed 7.1.14

Maudsley, Henry

Turner, Trevor. 'Maudsley, Henry (1835-1918)', *Oxford Dictionary of National Biography*, OUP, 2004 <http://www.oxforddnb.com/view/article/37747> accessed 19.3.2010

Mayer-Gross, Willy

Freeman, Hugh. 'Gross, William Mayer- (1889-1961)', *Oxford Dictionary of National Biography*, OUP, Jan 2011 <http://www.oxforddnb.com/view/article/51731> accessed 12.6.2012

Slater, Eliot. 'W. Mayer-Gross' *BMJ* (1961) i: 596-597

Meyer, Adolph

Gelder, Michael. 'Adolph Meyer and his influence on British psychiatry' 419-435. In: *150 Years* ed. Berrios and Freeman

Post, Felix

Arie, Tom. 'Remembering Felix' *Psychiatric Bulletin* (2002) 26: 199-200

Hilton, Claire. 'Felix Post (1913-2001) pioneer in the psychiatry of old age' *Journal of Medical Biography* (2007) 15: 31-36

Post, Felix. 'Then and now' *British Journal of Psychiatry* (1978) 133: 83-86

Post, Felix. 'In the beginning' 15-16. In: *Principles and Practice* ed. Copeland *et al.*

Rees, Linford

Richmond, Caroline. 'Linford Rees' *BMJ* (2004) 329: 744

Richter, Derek

Gaull, Gerald. 'Derek Richter, PhD MD 1907-1995' *Neurochemical Research* (1996) 21: 1267-1268

Roth, Martin

Gelder, Michael. 'Roth, Sir Martin (1917-2006)', *Oxford Dictionary of National Biography*, OUP, 2010 <http://www.oxforddnb.com/view/article/97473> accessed 12.6.2012

Richmond, Caroline. 'Sir Martin Roth' *BMJ* (2006) 333: 1175

Smith, Arthur Norman Exton-

Irvine, RE. 'Smith, Arthur Norman Exton- (1920-1990)', *Oxford Dictionary of National Biography*, OUP, 2004

<http://www.oxforddnb.com/view/article/57334> accessed 10.4.2013

Whitehead, Anthony (Tony)

Jolley, David. 'John Anthony Whitehead' *Psychiatric Bulletin* (2003) 27: 478

Williams, Ingeborg

Williams, Ingeborg. 'Experiences and reflections of a newly retired psychogeriatrician' *SPOA Newsletter* (Summer 1981) 2-11

Secondary sources

Books, chapters and journals

Allderidge, Patricia. 'The foundation of the Maudsley Hospital' 79-88. In: *150 Years* ed. Berrios and Freeman

Andrews, Jonathan. (ed.) *Lunacy's last rites: dying insane in Britain, c.1629-1939, History of Psychiatry* (2012) 23:

Arie, Tom. 'Martin Roth and the "Psychogeriatricians"' 231-238. In: *Contemporary Themes in Psychiatry: a tribute to Sir Martin Roth* ed. K Davidson, A Kerr (London: Gaskell, 1989)

Arie, Tom. 'The development in Britain' 9-11. In: *Principles and Practice* ed. Copeland *et al.*

Arie, Tom. Jolley, David. 'Psychogeriatrics' 260-265. In: *A Century of Psychiatry* ed. Hugh Freeman (London: Mosby-Wolfe, 1999)

Ballenger, Jesse. *Self, Senility, and Alzheimer's Disease in Modern America: a history* (Baltimore: Johns Hopkins University Press, 2006)

Baraclough, Joan. Dedman, Grace. Osborn, Hazel. Willmott, Phyllis. *100 Years of Health Related Social Work 1895-1995* (Birmingham: BASW, 1996)

Barham, Peter. *Closing the Asylum: the mental patient in modern society* (London: Penguin Books, 1997)

Barton, Alan. Mulley, Graham. 'History of the development of geriatric medicine in the UK' *Postgraduate Medical Journal* (2003) 79: 229-234

Berridge, Virginia. *Health and Society in Britain since 1939* (Cambridge: CUP, 1999)

Berridge, Virginia. 'Thinking in time: does health policy need history as evidence?' *Lancet* (2010) 375: 798-799

Berrios, German. 'Alzheimer's disease: a conceptual history' *International Journal of Geriatric Psychiatry* (1990) 5: 355-365

Berrios, German. 'Affective disorders in old age: a conceptual history' *International Journal of Geriatric Psychiatry* (1991) 6: 337-346

Berrios, German. 'A conceptual history in the nineteenth century' 3-5. In: *Principles and Practice* ed. Copeland *et al.*

Berrios, German. Freeman, Hugh. (ed.) *150 Years of British Psychiatry 1841-1991* (London: Gaskell, 1991)

Berrios, German. Porter, Roy. (ed.) *A History of Clinical Psychiatry: the origin and history of psychiatric disorders* (London: Athlone Press, 1995)

Bewley, Thomas. *Madness to Mental Illness: a history of the Royal College of Psychiatrists* (London: RCPsych, 2008)

Botelho, Lynn. Thane, Pat. 'Introduction' 1-12. In: *Women and Ageing in British Society since 1500* ed. Lynn Botelho, Pat Thane (Harlow: Longman, 2001)

- Bridgen, Paul. 'Hospitals, geriatric medicine, and long-term care of elderly people 1946-76' *Social History of Medicine* (2001) 14: 507-523
- Bridgen, Paul. Lowe, Rodney. *Welfare Policy under the Conservatives, 1951-1964: a guide to documents in the Public Record Office* (London: PRO, c.1998)
- Bridgen, Paul. Lewis, Jane. *Elderly People and the Boundary between Health and Social Care 1946-1991: whose responsibility?* (London: Nuffield Trust, 1999)
- Brooks, Jane. "'The geriatric hospital felt like a backwater': aspects of older people's nursing in Britain, 1955-1980" *Journal of Clinical Nursing* (2009) 18: 2764-2772
- Clark, David. *The Story of a Mental Hospital: Fulbourn 1858-1983* (London: Process Press, 1996)
- Cooper, John. *Pride versus Prejudice: Jewish doctors and lawyers in England 1890-1990* (Oxford: Littmann, 2003)
- Copeland, John. Abou-Saleh, Mohammed. Blazer, Dan. (ed.) *Principles and Practice of Geriatric Psychiatry* (Chichester: John Wiley and Sons, 2002)
- Crowther, MA. *The Workhouse System, 1834-1929: the history of an English social institution* (London: Methuen, 1983)
- Cummings, S. Savitz, L. Konrad, T. 'Reported response rates to mailed physician questionnaires' *Health Services Research* (2001) 35: 1347-1355
- Dedman, Grace. '1946-1973: reconstruction and integration: social work in the National Health Service' 21-47. In: Baraclough *et al.* *100 years of Health Related Social Work*
- De Hart, Jane Sherron. 'Oral sources and contemporary history: dispelling old assumptions' *Journal of American History* (1993) 80: 582-595
- Dormont, Brigitte. Grignon, Michel. Huber, Hélène. 'Health expenditure growth: reassessing the threat of ageing' *Health Economics* (2006) 15: 947-963
- Evans, J Grimley. 'Geriatric medicine: a brief history' *BMJ* (1997) 315: 1075-1077
- Gittins, Diana. *Madness in its Place: narratives of Severalls Hospital 1913-1997* (London: Routledge, 1998)
- Granshaw, Lindsay. *St Marks Hospital London: a social history of a specialist hospital* (London: King Edward's Hospital Fund for London, 1985)
- Granshaw, Lindsay. 'The rise of the modern hospital in Britain' 197-218. In: *Medicine and Society: historical essays* ed. Andrew Wear (Cambridge: CUP, 1992)
- Harris, Jose. 'The roots of public pension provision: social insurance and the Beveridge Plan' 27-38. In: *Britain's Pensions Crisis* ed. Hugh Pemberton, Pat Thane, Noel Whiteside (Oxford: OUP, 2006)
- Henwood, Melanie. 'No sense of urgency: age discrimination in health care' 43-57. In: *Age: the unrecognised discrimination: views to provoke debate* ed. Evelyn McEwen (London: Age Concern England, 1990)

- Henwood, Melanie. Wicks, Malcolm. *The Forgotten Army: family care and elderly people* (London: Family Policy Studies Centre, 1984)
- Hicks, Joe. Allen, Grahame. *A Century of Change: trends in UK statistics since 1900* (House of Commons Library, Research Paper 99/111, 1999)
- Higginson, I. 'Palliative and terminal care' 183-260. In: *Health Care Needs Assessment: the epidemiologically based needs assessment reviews* ed. Andrew Stevens, James Raftery (Oxford: Radcliffe, 1997)
- Hilton, Claire. 'The clinical psychiatry of late life in Britain from 1950 to 1970: an overview' *International Journal of Geriatric Psychiatry* (2005) 20: 423-428
- Hilton, Claire. 'The origins of old age psychiatry in Britain in the 1940s' *History of Psychiatry* (2005) 16: 267-289
- Hilton, Claire. 'A Jewish contribution to psychiatry: Edward Mapother, Aubrey Lewis and their Jewish and refugee colleagues at the Maudsley Hospital and Institute of Psychiatry 1933-1966' *Jewish Historical Studies* (2007) 41: 209-229
- Hilton, Claire. 'The provision of mental health services for people over 65 years of age in England 1970-78' *History of Psychiatry* (2008) 19: 297-320
- Hilton, Claire. 'Psychological therapies, older people and human rights' *Psychiatric Bulletin* (2009) 33: 184-186
- Hilton, Claire. 'Sans teeth, sans eyes, sans taste, sans everything: resourcing mental health services for older people' *Journal of the Royal Society of Medicine* (2012) 105: 146-150
- Hilton, Claire. Arie, Tom. Nicolson, Malcolm. 'A witness seminar: the development of old age psychiatry in Britain, 1960-1989. Themes, lessons and highlights' *International Journal of Geriatric Psychiatry* (2010) 25: 596-603
- Hirschman, Albert. 'Politics' 29-40. In: *The Ideas that Shaped Post-war Britain* ed. David Marquand, Anthony Seldon (London: Fontana Press, 1996)
- Howell, Trevor. 'The origins of the British Geriatrics Society' *Age and Ageing* (1974) 3: 69-72
- Howell, Trevor. 'Aspects of the history of geriatric medicine' *Proceedings of the Royal Society of Medicine* (1976) 69: 445-449
- Howells, John. 'The establishment of the Royal College of Psychiatrists' 117-134. In: *150 years* ed. Berrios and Freeman
- Jefferys, Margot. (ed.) *Growing Old in the Twentieth Century* (London: Routledge, 1989)
- Jefferys, Margot. 'Recollections of the pioneers of the geriatric medicine specialty' 75-97. In: *Oral History, Health and Welfare* ed. Joanna Bornat, Perks, Paul Thompson, Jan Walmsley. (London: Routledge, 2000)
- Jones, Edgar. 'Aubrey Lewis, Edward Mapother and the Maudsley' *Medical History* (2003) Supplement: 22: 3-38
- Jones, Edgar. Rahman, Shahina. 'Framing mental illness, 1923-1939: the Maudsley Hospital and its patients' *Social History of Medicine* (2008) 21: 107-125

- Jones, Kathleen. *Mental Health and Social Policy 1845-1959* (London: Routledge and Kegan Paul, 1960)
- Jones, Kathleen. *The Making of Social Policy in Britain 1830-1990* (London: Athlone Press, 1991)
- Jones, Kathleen. 'The culture of the mental hospital' 17-28. In: *150 years* ed. Berrios and Freeman
- Jones, Kathleen. *Asylums and After: a revised history of the mental health services: from the early 18th century to the 1990s* (London: Athlone Press, 1993)
- Kitwood, Tom. 'Dementia' 63-71. In: *History of Clinical Psychiatry* ed. Berrios and Porter
- Lester, Helen. Glasby, Jon. *Mental Health Policy and Practice* (London: Palgrave Macmillan, 2006)
- Levin, Bernard. *The Pendulum Years* (London: Jonathan Cape, 1970)
- Levy, Becca. 'Stereotype embodiment: a psychosocial approach to aging' *Current Directions in Psychological Science* (2009) 18: 332-336
- Lowe, Rodney. *The Welfare State in Britain since 1945* (Houndmills: Macmillan Press, 1999)
- McEwen, Evelyn. (ed.) *Age: the unrecognised discrimination: views to provoke debate* (London: Age Concern England, 1990)
- Martin, Moira. 'Medical knowledge and medical practice: geriatric medicine in the 1950s' *Social History of Medicine* (1995) 7: 443-461
- Means, Robin. Smith, Randall. *The Development of Welfare Services for Elderly People* (Kent: Croom Helm, 1985)
- Mendham, Marie-Clare. 'To age or not to age, that is the conundrum' *Old Age Psychiatrist* (2011) 53: 29-30
- Millar, Simon. 'Disability' 163-188. In: *Unequal Britain* ed. Thane
- Neuberger, Julia. 'Foreword' ix-xi. In: *Unequal Britain* ed. Thane
- O'Neill, Desmond. 'The art of the demographic dividend' *Lancet* (2011) 377: 1828-1829
- Peace, Sheila. 'The development of residential and nursing home care in the United Kingdom' 15-42. In: *End of Life in Care Homes: a palliative approach* ed. Jeanne Katz, Sheila Peace (Oxford: OUP, 2003)
- Pick, Daniel. *Faces of Degeneration: a European disorder, c.1848-c.1918* (Cambridge: CUP, 1989)
- Pomerleau, Joceline. McKee, Martin. *Issues in Public Health* (Maidenhead: Open University Press, 2005)
- Porter, Roy. 'Dementia' 52-62. In: *History of Clinical Psychiatry* ed. Berrios and Porter
- Porter, Roy. *Madness: a brief history* (Oxford: OUP, 2002)
- Pressman, Jack. *Last Resort: psychosurgery and the limits of medicine* (Cambridge: CUP, 1998)

- Rabins, Peter. 'The history of psychogeriatrics in the United States' *International Psychogeriatrics* (1999) 11: 371-373
- Ramon, Shulamit. *Psychiatry in Britain: meaning and policy* (London: Tavistock, 1985)
- Rogers, Anne. Pilgrim, David. *Mental Health Policy in Britain: a critical introduction* (Basingstoke: Macmillan Press, 1996)
- Rosen, George. *The Specialisation of Medicine with Particular Reference to Ophthalmology* (New York: Froben Press, 1944)
- Schieber, George. Poulter, Jean-Pierre. Greenwald, Leslie. 'Health system performance in OECD countries, 1980-1992' *Health Affairs* (1994) 13:100-112
- Schwartz, Myrna. Stark, Jacqueline. 'The distinction between Alzheimer's disease and senile dementia: historical considerations' *Journal of the History of the Neurosciences* (1992) 1: 169-187
- Scully, Andrew. *Decarceration: community treatment and the deviant – a radical view* (Cambridge: Polity Press, 1984)
- Scully, Andrew. 'Psychiatry and its historians' *History of Psychiatry* (1991) 2: 239-250
- Seshamani, Meena. Gray, Alastair. 'Ageing and health-care expenditure: the red herring argument revisited' *Health Economics* (2004) 13: 303-314
- Shorter, Edward. *A History of Psychiatry: from the era of the asylum to the age of Prozac* (New York: John Wiley, 1997)
- Shorter, Edward. *A Historical Dictionary of Psychiatry* (Oxford: OUP, 2005)
- Shorter, Edward. Healy, David. *Shock Therapy: a history of electroconvulsive treatment in mental illness* (New Brunswick: Rutgers University Press, c.2007)
- Shulman, Kenneth. 'The future of geriatric psychiatry' *Canadian Journal of Psychiatry* (1994) 39: 8: Supplement 1: S4-S8
- Stevens, Andrew. Raftery, James. (ed.) *Health Care Needs Assessment: the epidemiologically based needs assessment reviews* (Oxford: Radcliffe, 1997)
- Stevens, Rosemary. *Medical Practice in Modern England: the impact of specialisation and state medicine* (New Haven: Yale University Press, 1966)
- Stewart, John. 'The scientific claims of British child guidance, 1918-1945' *British Journal for the History of Science* (2009) 42: 407-432
- Szasz, Thomas. *Coercion as Cure: a critical history of psychiatry* (New Jersey: Transaction Publishers, 2007)
- Tallis, Raymond. *Hippocratic Oaths* (London: Atlantic Book, 2004)
- Tansey, EM (Tilly). 'The witness seminar technique in modern medical history' 279–295. In: *History of the Social Determinants of Health: global histories, contemporary debates* ed. Harold Cook, Sanjoy Bhattacharya, Anne Hardy (Hyderabad, India: Orient BlackSwan, 2008)
- Tantam, Digby. 'The anti-psychiatry movement' 333-347. In: *150 Years* ed. Berrios and Freeman (London: Gaskell, 1991)

- Thane, Pat. *The Foundations of the Welfare State* (London: Longman, 1982)
- Thane, Pat. 'The debate on the declining birth-rate in Britain: the "menace" of an ageing population, 1920s-1950s' *Continuity and Change* (1990) 5: 283-305
- Thane, Pat. 'Geriatrics' 1092-1115. In: *Companion Encyclopedia of the History of Medicine* ed. William Bynum, Roy Porter (London: Routledge, 1993)
- Thane, Pat. *Old Age in English History: past experiences, present issues* (Oxford: OUP, 2000)
- Thane, Pat. *Happy Families? History and Family Policy* (London: British Academy, 2010)
- Thane, Pat. 'Older people and equality' 7-28. In: *Unequal Britain* ed. Thane Thane, Pat. (ed.) *Unequal Britain* (London: Continuum, 2010)
- Thane, Pat. *Demographic Futures* (London: British Academy, 2012)
- Thompson, Paul. *The Voice of the Past* (Oxford: OUP, 2000)
- Thompson, Paul with Rob Perks, *An Introduction to the use of Oral History in the History of Medicine* (London: British Library, 1993)
- Walk, Alexander. 'Psychiatry in the 1870s: centenary of the Mental After-Care Association' *Psychiatric Bulletin* (1979) 3: 122-123
- Walt, Gillian. *Health Policy: an introduction to process and power* (London: Zed Books, 1994)
- Walter, G. 'The stereotype of the mad psychiatrist' *Australian and New Zealand Journal of Psychiatry* (1989) 23: 547-554
- Watts, Geoff. 'Why the exclusion of older people from clinical research must stop' *BMJ* (2012) 344: 23-24
- Webster, Charles. *The Health Services since the War. Vol. 1. Problems of Health Care: the National Health Service before 1957* (London: HMSO, 1988)
- Webster, Charles. 'The elderly and the early National Health Service' 165-193. In: *Life and Death and the Elderly* ed. Margaret Pelling, Richard Smith (London: Routledge, 1991)
- Webster, Charles. *The National Health Service: a political history* (Oxford: OUP, 1998)
- Webster, Charles. 'Something to celebrate: the BMA and the NHS' *BMJ* (1998) 317: 45-47
- Webster, Charles. 'Psychiatry and the early National Health Service: the role of the Mental Health Standing Advisory Committee' 103-116. In: *150 years* ed. Berrios and Freeman
- Weisz, George. 'The emergence of medical specialization in the nineteenth century' *Bulletin of the History of Medicine* (2003) 77: 536-575
- Weisz, George. *Divide and Conquer: a comparative history of medical specialization* (New York: OUP, 2006)

Welshman, John. 'Growing old in the city: public health and the elderly in Leicester 1948-74' *Medical History* (1996) 40: 74-89

Welshman, John. 'Rhetoric and reality: community care in England and Wales 1948-74' 204-226. In: *Outside the Walls of the Asylum: history of care in the community 1750-2000* ed. Peter Bartlett, David Wright (London: Athlone Press, 1999)

Willcox, R. 'Fifty years since the conception of an organised venereal diseases service in the United Kingdom' *British Journal of Venereal Diseases* (1967) 43: 1-9

Wilmott, Phyllis. '1895-1945: the first 50 years' 1-11. In: Baraclough *et al.* *100 years of Health Related Social Work*

Websites: secondary sources

Age UK

<http://www.ageuk.org.uk/about-us/who-we-are/our-history/> accessed 30.4.2013

Alzheimer's Society

'Our history'

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=81
accessed 30.4.2013

Centre for Policy on Ageing

http://www.cpa.org.uk/cpa/about_cpa.html accessed 23.10.2011

History of Modern Biomedicine Research Group

'What is a witness seminar'

<http://www.history.qmul.ac.uk/research/modbiomed/what-is-a-witness-seminar/index.html> accessed 22.5.2012

Leeds Institute of Health Sciences

Academic Unit of Psychiatry and Behavioural Sciences,
<http://www.leeds.ac.uk/lihs/psychiatry/> accessed 9.4.2013

Mind

'A history of Mind'

http://www.mind.org.uk/about/what_we_do/a_history_of_mind accessed 30.4.2013

National Archives

Hospital Records Database,

<http://www.nationalarchives.gov.uk/aboutapps/hospitalrecords/default.htm>

accessed 15.1.2013

‘Move to 20 years rule begins’

<http://www.nationalarchives.gov.uk/news/797.htm> accessed 21.4.2013

‘Open government licence for public sector information’

<http://www.nationalarchives.gov.uk/doc/open-government-licence/> accessed 29.3.2013

Sandbrook, Dominic. ‘Sixties Britain: introduction’

<http://www.nationalarchives.gov.uk/education/topics/sixties-britain.htm>

accessed 13.3.2013

Oxford Dictionary of National Biography, <http://www.oxforddnb.com/>

accessed 12.5.2013

Oxford English Dictionary, www.oed.com accessed 30.11.2012

Pensioners’ Voice

<http://www.pensionersvoice.co.uk/content/information/the-story-of-the-pensioners-voice> accessed 11.11.2011

Rivett, Geoffrey.

National Health Service History <http://nhshistory.net/cvgodber.html> accessed 21.2.2012

Royal College of Psychiatrists

On-line archive, ‘Substance misuse’

<http://www.rcpsych.ac.uk/publications/books/rcpp/9781904671350/extra9781904671350.aspx> accessed 4.8.2012

Taylor, Jeremy. Cornwell, Simon. Cracknell, Peter.

‘The Asylums List’

<http://www.thetimechamber.co.uk/beta/sites/asylums/asylum-history/the-asylums-list> accessed 15.5.2013

Unpublished dissertations

Denham, Michael. 'The history of geriatric medicine and hospital care of the elderly in England between 1929 and the 1970s' (PhD Thesis, University College London, 2004)

Greenhalgh, Charlotte. 'An age of emotion: expertise and subjectivity in old age in Britain, 1937-1970'. Chapter: 'Old age policy in practice: the residential home' (DPhil Thesis (Draft), University of Oxford, 2012)

Rennie, Sandra. 'The voluntary sector: a case study - the Parkinson's Disease Society 1969-1993' (BSc Dissertation, University College London, 1993)

Toth, Benjamin. 'Clinical trials in British medicine 1858-1948 – with special reference to the development of the randomised controlled trial' (PhD Thesis, University of Bristol, 1998)

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